Getting to know you

detailed history is an essential element in understanding the background to a patient's oral health and planning effectively for their present and future treatment - Dental Protection

Before providing any treatment, it is a clinician's responsibility to ask the right questions, in the right way, and to listen carefully to the patient's responses. If an important aspect of a patient's history does not come to light in the consultation process, and problems arise as a result of this, attention tends to focus upon the clinical records and what they do (and do not) contain. In the absence of any evidence that certain key questions were ever asked, it is extremely difficult to determine at a later date that they were.

If, on the other hand, there is a lack of information, perhaps in a medical history questionnaire which has been completed (and preferably, signed and dated) by the patient on a particular day, then there can be no doubt that the clinician asked the relevant question and was entitled to work from the assumption that the answer(s) given were correct.

Four specific areas of the patient's history are worthy of particular consideration in this brief overview:

• Medical history
• Dental history
• Personal/social history
• History of the presenting complaint (if any)

General observations

Creating any history about a patient but are of limited value when trying to establish confidence and dressing has taken place to update the answer. It is worth establishing a routine that may change as time passes. These questions tend to begin with: What? Why? When? How? etc and because of this, they require the patient to provide more information for you in their reply. This is often helpful when dealing with less communicative patients, or when you are hoping to gather information of a better quality, and in greater detail.

• ‘Why’ questions

These questions, which are a specific kind of open question, can be extremely useful. They are used when dealing with patients who seem not to understand the meaning of open questions and can thereby speed up the information gathering process.

Leading questions

These questions tend to be worded in such a way as either to suggest the answer or to invite a specific reply. For example ‘Have you been wearing your appliance, haven’t you?’ They can be useful when trying to establish confidence and communication with a nervous, quiet, or uncommunicative patient but are of limited value when trying to elicit or act upon a relevant aspect of medical history leads to a patient’s best interest, but is also that this fact is clearly beyond the patient, in what terms, and what answers were given. Clearly, a well structured medical history questionnaire form, which is completed, signed and dated by the patient, and subsequently dated on a regular basis (ideally, during each successive course of treatment), is not only in the patient's best interest, but is also the best platform for the successful defence of cases where failure to elicit or act upon a relevant aspect of medical history leads to avoidable harm to the patient. In all cases, the taking and confirmation of a medical history is the role of the dental surgeon and if in doubt, it may be sensible to defer treatment pending clarification of any areas of uncertainty in a patient's medical history.

Dental history

However thoroughly it is carried out, any clinical examination is still only a snapshot of a patient's dental and oral tissues at a moment in time. While it will provide a lot of useful basic information, the clinician's understanding of the patient's presenting condition is greatly improved by knowing how the patient reached the present position.

Is there a history of fractured teeth/fillings?

Are any teeth painful or sensitive?

If so, what causes any such sensitivity?

Do the patient's gums bleed on tooth brushing or spontaneously?

Is the patient apprehensive about receiving dental care?

If so, do these concerns relate to any particular dental procedure(s) or to the experience in general?

Has the patient experienced any particular problems associated with treatment provided for them in the past? If so, what?

Not only will questions like those above help to inform the clinician regarding areas which may or may not need treatment, or which should be kept under review, they will also guide the clinician regarding the success, or failure, of treatment approaches that have been tried in the past. If this knowledge helps the clinician to avoid repeating the previous mistakes of other clinicians, it can also help to avoid claims and complaints that might otherwise have resulted.

Social history

The social history should include details of employment (and interests, hobbies, etc) as well as other social and family related information. The patient's occupation should be included in the consideration of relevant factors affecting diagnosis, treatment planning, consent and treatment, bearing in mind the fact that this is an aspect of a patient's history that may change as time passes. It is worth establishing a routine of checking the patient's contact details and employment, when carrying out a periodic update of the patient's medical history.

The ability to attend for appointments could affect the success of complex or extensive treatment, eg crown and bridgework, implants, long term periodontal treatment and orthodontics. Certain occupations can place severe constraints on a patient’s ability to attend regularly for appointments.

Issues relating to a patients employment or recreational interests may have an impact on treatment:

For example:

• Bruxism in air traffic controllers, marathon runners and certain other sports players

Many practices take medical histories verbally and if no positive or significant responses are elicited, an entry such as 'MH - nil' is made in the records. While better than nothing at all, this approach carries the disadvantage that it can be difficult or impossible to establish precisely what questions were asked of the patient, in what terms, and what answers were given. Clearly, a well structured medical history questionnaire form, which is completed, signed and dated by the patient, and subsequently dated on a regular basis (ideally, during each successive course of treatment), is not only in the patient's best interest, but is also the best platform for the successful defence of cases where failure to elicit or act upon a relevant aspect of medical history leads to avoidable harm to the patient. In all cases, the taking and confirmation of a medical history is the role of the dental surgeon and is certainly a key part of a dentist's duty of care. If in doubt, it may be sensible to defer treatment pending clarification of any areas of uncertainty in a patient's medical history.

• Are any positive or significant responses were ever asked, it is extremely difficult to determine at a later date that they were.
The outcome of treatment can have a general effect or a more specific effect on a given patient. For example, chronic severe pain, which can arise from some form of nerve damage, or TMJ/muscle disturbance associated with dental procedures, or perhaps a facial paralysis, or permanent loss of sensation in the lip or tongue, would all be likely to reduce the quality of life for most patients.

On the other hand, the loss of ability to articulate clearly when speaking or singing, because of a change in the anterior tooth shape, position or angulation, or perhaps because of lingual or inferior alveolar nerve damage, would have a more profound affect on an opera singer, lecturer or telephone than for an agricultural worker who did not depend upon singing for his livelihood. Similarly, there are many jobs in which appearance is important and an adversely altered appearance can either lose a patient a job or severely affect a patient's confidence, particularly if they have to face the public in their working life. Awareness of information such as this is critical when contemplating any aesthetic/cosmetic procedures.

History of present complaint
When a patient attends with a specific problem it is helpful to know how long the problem has existed, when it was first noticed, whether it has ever occurred before, whether any previous treatment has sought to resolve the problem and if so, with what success.

If the patient is complaining of pain, for example, it is helpful to know what kind of pain it is (dull ache, or throbbing, or acute bursts of pain), or how long it lasts, and what makes it worse or better and whether it has occurred previously and if so under what circumstances.

Each of these findings needs to be recorded carefully in the notes to demonstrate this important part of the diagnostic process. The significance of this becomes apparent on occasions when a mistaken diagnosis is made. If, however, the diagnosis is supported by the information which was available to the clinician at the time, as noted in the records, such situations can often be defended successfully.

Summary
It will be appreciated that there is very little value in gathering information from the above sources if the responses are not collected and recorded in a clear and logical fashion. Having a structured and systematic approach to history taking and record keeping makes it less likely that critical information will be overlooked, or lost.

Later in the treatment planning process, when it becomes a little clearer what treatment possibilities are under consideration, it may be necessary to explore some aspects of the history in greater depth, in order to ensure that the patient is aware of any way in which their treatment (and its prognosis) might be affected by some aspect of their history.

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