

Putting Premortem Ethics Into Practice

Improving Colleague Relations by Thinking Ahead

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In our last article ("How to Limit Unintended Outcomes," *AGD Impact*, January 2014), we described how to reduce unplanned and/or bad outcomes in the dental office through the use of preventive or "premortem" ethics. We stressed that dentists must work closely with everyone on their staff in three ways. First, open communication among everyone in the office needs to be the normal routine. Second, the entire team needs to participate in a formal procedure that asks in advance, "What might go wrong here?" and in doing so establishes an explicit premortem procedure in which everyone participates. Third, when unplanned outcomes do occur, the office must remain united in the commitment that whatever happens is the result of the group's work. No one person should be identified for blame. Instead, the team must always ask, "How did this slip through despite so much effort from *all* of us?" and "How can *we* fix the system so this does not happen again?"

Of course, unintended and/or bad things also happen beyond the walls of the dental office—not only in the interactions of dentists from different offices caring for the same patient, but also in the interactions of dentists working in the same community and as professional colleagues. We suggest that, again, having an explicit premortem procedure in place may be helpful in reducing the number and negative impact of unintended and/or bad outcomes in dentists' interactions with one another. In order to take this approach, you must first compare two different views of dentists' most basic relationships with each other, and this in turn involves comparing two different ways in which members of a modern society view one another.

Considering two views

Are dentists in our society first and foremost a community of people with common goals and a shared desire to work toward those goals together? Or are they first and foremost competitors whose

goals have no essential relationship to one other, with each striving to advance his or her goals regardless of the impact these actions might have on others? ("Dental Professionalism," *AGD Impact*, August 2011.)

These questions may strike some readers as too abstract to be worth considering. Or, it may seem that the "my-success-above-all" viewpoint is obviously correct, because people who run a business in today's society are unavoidably competitors, and anyone who thinks otherwise is just asking to be taken for a ride. But this doesn't take into consideration that being a professional means being a member of a profession, which is a community of people with common goals and a shared desire to work toward those goals together.

But a dentist's commitment to serving patients as effectively as possible, whether as a matter of deep principle or simply because it is good business, does not dictate how he or she will relate to fellow dentists. So this question deserves some careful attention.

In addition, dentists' interactions with one another do not take place in a social vacuum. They exist in the context of modern society, where most dental care is available only from offices and clinics that operate as businesses, striving to succeed in the free enterprise marketplace. They have no option but to interact with other health professionals, hospital systems, insurance carriers, etc., that also function as participants in the free enterprise marketplace.

Nor can any of these avoid interacting with other, typically more powerful, social systems, especially legal systems and systems of public policy/regulation, which have strong commercial and political foundations. In other words, there are a lot of forces and factors challenging dentists to set aside the reality that they are professionals and therefore members of a community with common goals, and prompting them to interact as marketplace competitors instead.

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This is why premortem ethical thinking about dentists' interactions with dentists in other offices and beyond is ethically so important. No matter how committed an individual dentist is to living and practicing as a professional in his or her own office—with his or her patients and staff—an essential element of professional ethics is lost if the dentist's commitment to practicing like a professional does not extend to his or her relationships with other dentists.

It is important for dentists to do some serious premortem ethical thinking, individually and especially together, to make this kind of shortfall from professionalism less likely. For many dentists, this will mean learning new ways of interacting with one another—just as many dentists must do within the office.

A case to consider

For the remainder of this article, we will return to the three necessary characteristics of a group that is committed to effective premortem ethical thinking, which we identified in our previous article. There, we gave examples of these characteristics in the dental office setting.

In this article and the next, we will give some examples of these characteristics as they are found or could be found in the interactions of dentists from different offices who are striving to relate to one another as members of the same professional community. This article will focus on some "simpler" or "easier" examples—although interprofessional relationships are rarely simple and easy—while the next article will explore some of the more difficult, complex aspects of dentist-dentist interactions

that require premortem ethical thinking.

The three necessary characteristics of a group that is committed to effective premortem ethical thinking are:

1. Having a particular shared attitude toward communication within the group
2. Establishing concrete procedures for explicit preventive or premortem discussions about potentially divisive issues
3. Maintaining a shared attitude, while remaining united and responding as a community even if bad, divisive, or unplanned events or challenges occur

Consider this scenario: Dr. Travel planned to be out of his office for three weeks and asked Dr. Jones to cover for him. Dr. Travel offered all of his patients the usual cautionary advice to call the

office with any questions or concerns and provided information on how to reach the covering dentist. Additionally, he individually advised a few recently treated patients to call him immediately if they should experience specific symptoms relating to their treatment.

Dr. Travel also requested that Dr. Jones call him as soon as possible if he should need to see any of those recently treated patients. Dr. Jones responded, "Glad to help; please enjoy yourself while you can—it will all still be here when you return."

A week later, one of these patients, Mr. Richards, came in to see Dr. Jones and expressed concern about a temporary bridge that Dr. Travel had recently placed. Dr. Travel had seen Mr. Richards for an emergency a few weeks earlier after he broke his maxillary right central incisor "biting down on a metal fishing hook." The lateral incisor next to it had previously been repaired. The tooth was not painful but had a severely resorbed root with a large radiolucency and was beyond repair. A porcelain veneer crown on the right maxillary cuspid, which also had received root canal treatment and a post, was slightly tender to touch, and its porcelain facing was fractured from the metal base.

From the beginning of their dentist-patient relationship, Dr. Travel and Mr. Richards hit it off well—both of them fish, and they enjoyed much small talk about that. After discussing several options, Dr. Travel and Mr. Richards settled on removing the non-repairable lateral and replacing it with a temporary bridge from the central to the cuspid; that would solve Mr. Richards' immediate esthetic needs and eliminate some of the extreme sensitivity on the central incisor.

The transitional bridge seemed to be the most reasonable, agreeable, and affordable first step until Dr. Travel was more certain that the abutment teeth were stable enough to proceed further. The provisional treatment also gave Mr. Richards time to decide if he really wanted to invest in a bridge, given his budget and how much his insurance would cover. Dr. Travel had advised him that root canal treatments and additional restorative work might be needed,

depending on what they found when there was time for a complete exam.

While meeting with Dr. Jones, Mr. Richards explained that he really liked what Dr. Travel did to help him out of his situation on short notice and that it made everything better for a week. But then he started to notice some soreness around the tooth just behind the maxillary right cuspid serving as one of the bridge abutments, and it seemed to be getting a little worse despite the medications he received from Dr. Travel.

Dr. Jones noted that Mr. Richards had excellent hygiene and healthy gingival tissue, but found that a probe went down 12 mm behind the cuspid supporting the provisional bridge and on the distal of the maxillary first bicuspid directly behind it. Because the probing was only 2 mm or less around the rest of these two teeth and the deep probing was only along a very narrow slot, Dr. Jones suspected that the two teeth were cracked along their entire length.

He told Mr. Richards that he liked the way Dr. Travel and he decided to take care of his earlier need, but that he would need to talk more with Dr. Travel to decide the best way to take care of Mr. Richards' current soreness. Dr. Jones said he would call Dr. Travel and then call Mr. Richards about the best next steps.

Mr. Richards agreed with this plan, saying he really was OK for now—he just wanted to know what was going on. But just as he was about to leave, Mr. Richards asked Dr. Jones if everything really was OK, or if Dr. Jones thought it would be better to take an impression right now so Mr. Richards could get a more permanent bridge sooner.

"I will call Dr. Travel right away," Dr. Jones said. "I will get back to you as soon as I hear his recommendation."

"OK," Mr. Richards said. "As long as you are not concerned that this temporary thing is a mistake, I will wait for your call."

An ethical examination

There are many premortem issues—things that could go wrong that are worth thinking about in advance—that could be discussed regarding Mr.

Richards' emergency care and likely subsequent care. But our concern here is with the relationship between Drs. Travel and Jones.

There are a number of things that premortem ethical thinking would identify regarding what might go wrong or in other ways complicate Dr. Jones' need to initiate a conversation with Dr. Travel. The most obvious of these is what Dr. Jones ought to do about caring for Mr. Richards if he cannot reach Dr. Travel fairly quickly—say, within 24 hours. What if several days pass without a response from Dr. Travel? What information and treatment recommendations should Dr. Jones offer Mr. Richards if his discomfort remains stable or improves, or if his discomfort increases but is still manageable with increased pain medication and there are no additional symptoms? What if it isn't manageable with pain medication?

The marketplace model of competitor relationships would instruct Dr. Jones to take advantage of Mr. Richards' concerns by implementing a permanent solution to his problem as soon as possible. In fact, Dr. Jones knows that they are probably now talking about a lot more work than a permanent, three-unit bridge. All he had to say was, "We could get started on solving this right now if you would prefer. I do need to tell you that the abutment teeth that are bothering you, the ones that Dr. Travel had hoped to use for the bridge, appear on my initial examination to have serious problems themselves. Dr. Travel will be gone for another two weeks, so if you would like me to get going on this, I am certainly willing to help you." No deception or disparaging remarks about Dr. Travel would be involved—just the objective facts about the condition of Mr. Richards' mouth and Dr. Travel's whereabouts.

But in resisting this opening and reiterating the appropriateness of his contacting Dr. Travel, Dr. Jones already has demonstrated an ethical conviction that he and Dr. Travel have a mutual agreement about coverage, and that they are professionals who are caring for the same patient together as a team. In other words, Dr. Jones has exhibited

the first characteristic of premortem ethical thinking: a commitment to shared communication within the relevant professional community. In fact, both dentists in this story demonstrated this commitment in establishing their coverage agreement in the first place—provided they saw this not only as a mark of good patient care, but also as the proper way for professionals who are caring for the same patient to interact.

Additionally, in making their coverage agreement, they fulfilled at least part of the second characteristic of premortem ethical thinking: the establishment of a concrete procedure to deal with unexpected eventualities. But their conversation did not include the possibility of Dr. Jones' inability to reach Dr. Travel in a reasonable amount

of time if one of Dr. Travel's recent patients did show up in need.

If the two doctors had a history of covering for each other, it would be easy to imagine that they had already come to trust each other's best judgment, both about what to do for a given patient's needs and when to do it. As in an office that has had premortem conversations in place, the amount of explicit detail necessary for each patient would decrease as the parties grew more familiar with each other's ways of dealing with the unexpected. But if this coverage agreement took place early in the doctors' dealings with each other, more information about the patients with whom Dr. Travel was most concerned might have made it easier for Dr. Jones to think ahead.

If this is the case, and if Dr. Jones cannot reach Dr. Travel when he calls him multiple times, what should Dr. Jones do? The logic of the marketplace would, as above, instruct Dr. Jones to take over the case if Mr. Richards agrees, even if his symptoms became no more severe. Dr. Travel will, after all, be away for some additional time, and given the condition of Mr. Richards' teeth, things could get much worse for him in a hurry. Wouldn't it be better,

the market mentality would say, to initiate a permanent intervention rather than risk another emergency?

But the third characteristic of a community that practices premortem ethics is that, when something does "go wrong," the caring team remains united and responds *as a community*, asking not who is to blame, but rather how

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everyone involved is responsible and could prevent similar situations in the future. Let us suppose that Dr. Jones' attempts to reach Dr. Travel fail.

First, the caring team should remain united; that is, Dr. Jones should maintain the view that Mr. Richards is temporarily *both* dentists' patient, not just his own—even if he is fairly certain that the patient would agree to Dr. Jones' initiating a permanent intervention right away. This means that if Dr. Travel's temporary measures do in fact work for Mr. Richards, with the help of appropriately moderated pain medication, until Dr. Travel returns, then that is what ought to happen.

Second, Dr. Jones should not undertake a more detailed examination of Mr. Richards' situation unless Mr. Richards' symptoms change and a more detailed examination cannot be delayed.

Third, Dr. Jones should not propose or even support the idea that Dr. Travel is careless because he is unavailable for consultation while out of town. After all, Dr. Travel did plan for patient coverage.

Of course, if Mr. Richards' symptoms change for the worse, then the member of this two-dentist team who is on the scene must respond appropriately, but even then, Dr. Jones' ethical view

should be that he is responding on behalf of both doctors—not just because he is a dentist and this is a patient with emergent needs, but because he and Dr. Travel are professionals who are caring for Mr. Richards as a team.

Why speak of these attitudes as premortem ethical attitudes? When patients

need care, a good dentist will do his or her best to provide it. However, unless that dentist stops to think ahead of time about what it means to interact as members of the same profession, providing coverage care for an absent dentist may seem no different than other emergent care situations. A dentist may not reflect on the reality that, as fellow members of the dental profession, the two dentists involved ought to view

themselves as a dental *team* in the care of the same patient (i.e., as members of a community of dentists with shared goals and shared expertise to meet peoples' oral health needs).

Thinking of coverage care in this way may not be a great stretch for most dentists, even in the face of the pressures from many sides to think about dentistry in marketplace terms. But there are other areas of dentist-dentist interactions in which maintaining the ethical attitude that we are fellow professionals practicing together is much harder. We will examine some examples in our next article. ♦

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