Reflection On My Personal Practice Example 1

In consultation with the dentist (GDP), dental nurse and dental hygienist, a decision was recently made to provide children with their own personalised oral hygiene kits when they attended the surgery for routine hygiene appointments. This decision was made following the application of some literature to practice.

I recently treated an Autistic child of twelve years old who had been with the practice for 6 months. The child had been given an oral hygiene kit comprising a toothbrush, floss, disclosing tablets, fluoride mouth rinse and a dietary analysis sheet. The child had three filled permanent teeth, and had a previous history of dental caries experience and extractions of his deciduous teeth. In addition, the GDP is currently watching other early stages of decalcification. When I reviewed him after he had been using his oral hygiene kit there were some signs of improvement in his plaque indices, but further improvement was necessary. A review of his dietary analysis form showed that he had a diet where he would only eat very little, and so his parents allowed him to snack throughout the day. After educating the parents and child on the causes of decay, I started to consider other interventions that could be put in place, to improve the oral health of the child.

The Department of Health (DoH, 2005, p.13) observe that “In 1973, 93% of 12 year old children had tooth decay in England; by 2003 this had fallen to a historic low of 38%.” Despite this improvement, Hawkins et al (2003, p.313) observe that “not all children however, have experienced the same degree of caries risk reduction, and dental decay remains a significant problem for a substantial minority of high risk children.” The DoH (2007, p.10) state that “when considering the desired outcome of controlling or preventing caries, currently the evidence suggesting the effectiveness of efforts to change diet is not as strong as the evidence supporting increasing fluoride.” I therefore decided to consider the application of fluoride as a possible preventative measure that could be employed.

I decided to research the current evidence-based recommendations for children that may be considered to be at high risk of developing caries. The DoH (2007, p. 10) advise that children that may be considered more likely to develop caries or those with special needs should have shorter recall appointments, application of fluoride varnish 3-4 times per year and the prescription of fluoride toothpaste at 2,800 ppm should be considered. Marinho et al. (2003) state that “the benefits of topical fluorides have been firmly established on a sizeable body of evidence from randomised controlled trials.” When deciding the delivery of topical fluorides I felt it was important to consider the potential risks of toxicity. The fluoride varnish has been considered to produce a lesser risk of toxicity than the fluoride gel (Hawkins, 2003, p.314), however the risk of toxicity is questionable providing aspiration is carried out and the trays are not over-loaded (Andlaw & Rock, 1996, p.46). Hawkins et al (2003, p.314) observe that “the advantage of varnish is in its ability to adhere to the tooth surfaces which prolongs contact time between fluoride and enamel and improves fluoride update into the surface layers of enamel.”

In consultation with the GDP and the child’s parents, it was decided that the child should have fluoride varnish applied three times a year and that a fluoride toothpaste containing 2,800 ppm of fluoride would be prescribed in line with the current
Evidence based recommendations for children considered to be at high risk of developing caries (DoH, 2007, p.10).

Evaluating the outcome will take time in terms of assessing the future caries incidence for the child concerned, however in a Cochrane Review of four studies, the average decayed, missing and filled teeth (DMFT) prevented fraction was 40% (Marhino, 2008, p.5). Patient compliance during the treatment was good, and the child and his parents appeared to be motivated regarding dietary changes, improving oral hygiene, and the use of a high fluoride toothpaste. Due to the positive views elicited following the treatment of this child, topical fluoride applications are now considered for other children and also adults that may be considered to be at higher risk of developing caries. These patients include those with three or more carious lesions in 3 years, patients with a cariogenic diet, patients undergoing orthodontic therapy, those with a low socio-economic status, patients with exposed root surfaces, teeth with developmental abnormalities, patients with xerostomia, patients with poor oral hygiene and patients with special needs (American Dental Association, 2006). The DoH (2000, p.13) state that “economic deprivation, social exclusion and some cultural differences all help to create an environment where oral hygiene suffers, but the evidence suggests that fluoridation can help to bring oral health in a deprived area up to around the level of a more affluent area.” If the water in the area is fluoridated the situation will again be reviewed, but as a preventative measure, topical fluoride applications will be considered for patients at higher risk of developing caries, in order to raise the standard of oral health of the patients within the practice.

References


Reflection on My Personal Practice Example 2

A patient with poor periodontal status and poor oral hygiene came to see me for her regular three monthly scale and polish. I have been treating this lady for three years and she has proved to be very difficult to motivate as she always appears uninterested in her oral health status, wants me to finish treatment as quickly as possible, and states that she would rather lose her teeth anyway. If I try to offer advice she is rude and uninterested, and I have recently taken to completing her treatment as best I can and saying very little due to the response I get.

On this particular day she brought in a newspaper article with the headline “life’s too short to stuff mushrooms!” She informed me that this is what she thought of flossing so not to even try to mention it.

I have identified that I often don't give difficult people all the questioning and information that is required, for fear of their response and I know I have to make changes to my current practice. I found myself doing some very quick Reflection-in-action and Reflecting-on-action from my previous experiences. Schon, D (1987, cited in Smith 2001) state "The practitioner allows himself to experience surprise, puzzlement, or confusion in a situation which he finds uncertain or unique. He reflects on the phenomenon before him, and on the prior understandings which have been implicit in his behaviour. He carries out an experiment which serves to generate both a new understanding of the phenomenon and a change in the situation."

I felt worried about talking to this patient as she is so volatile I thought she may just leave the surgery. I looked at the newspaper article and shared a joke with her about it, and then told her that flossing is nothing like 'stuffing mushrooms', because even if she didn't care about her oral health, it could have an impact on her general health too. She made a comment that she did not care, but I could tell she was a little interested. I thought back to my learning on Visual, Auditory and Kinaesthetic learning styles (VAK) and also another article I had read. According to Dunn et al. (1989) learning styles are "a biologically and developmentally imposed set of personal characteristics that make the same teaching method effective for some students and ineffective for others." While I was treating her I explained to her that some recent research suggests that there may be a possible link between gum disease and heart disease. Davies and Davies (2005, p.439) state that "a meta-analysis of nine studies, involving a total of 107,011 individuals, found that periodontal disease increased the risk of future cardiovascular disease by 19%". I directed the patient to look at a website as I know she likes looking up information on the internet. I also went through her deteriorating periodontal status and explained the aetiology again. I did this both verbally in case she had a preferred style of being Auditory, and I also used diagrams in case she was a Visual learner. I then allowed her to handle the tooth model I had which would help if she was a kinaesthetic learner. I also explained the potential consequences of not improving things. She did stop me and tell me not to bother because she's be quite happy to lose her teeth and not have to see me again, and at that point I nearly gave up. Instead I patiently attempted to explain the disadvantages of dentures, but explained to her that ultimately the responsibility of improving her oral health lay with her.
I was surprised by her reaction. At the end of the appointment she said to me- 'well I suppose as you've been on about it so much you'd better show me this floss again!' I demonstrated the technique again, explained the bleeding again and I am quietly hopeful she may give it a go.

This was such an interesting experience because I always prefer to avoid conflict. I felt that at the end of the appointment she almost had respect for me for standing up to her, and she even smiled as she left the room. Whether anything changes with her oral hygiene remains to be seen, but it has definitely given me confidence to stand up to these difficult people and keep on trying with them.

Three months later I now have the opportunity to reflect and evaluate this cycle as the patient in question returned for her three monthly appointment with me. Her attitude with me had completely changed and she had made every effort to improve her oral health. She had looked up information on the web site I had directed her to, and said she was now keen to improve her periodontal status. Since treating her three months ago I have had a couple of patients with a similar attitude to her, and I have also kept persevering with them too. This cycle of events has increased my confidence in persevering with the few difficult patients I have, as it really shows that handling them in a slightly different way, can produce improvements.

Returning to this reflection again in order to further evaluate this cycle, made me question the point at which the patient decided to make the change to improve her oral health. I have been treating this patient for 3 years and have not had previous success in motivating her to change. By recognising and evaluating what it may have been that made her change, I may be able to apply this to other patients in order to further improve my professional practice and assist patients in improving their oral health.

Reflecting on the cycle again has made me consider that the change may have been due to my improved confidence at dealing with the patient, the consideration of her possible learning styles, or that mentioning the possible link with heart disease caused her to consider another factor in maintaining oral health. I decided to research the models of health behaviour and stages of change.

Kent & Croucher (2001, p.57) state that “Psychologists and sociologists have developed several models or theories which can be used to explain why and when patients will put effort into achieving health”.

The Health Belief Model works on the theory that the patient has to believe the potential seriousness of the disease and that there are benefits to avoiding the potential consequences. With this theory the patient is given a cue that leads them to making change (Tate, P, 2006, cited by G.P Training.net, 2006). The Theory of Planned Behaviour suggests that the patient needs to have the attitude to want to change (Kent & Croucher, 2001, p.57). Another approach that can be considered is the Stages of Change Model that suggests that patients go through 5 stages of change (Prochaska & DiClemente, 1992, cited by Kent & Croucher, 2007, p.58). I decided to relate these 5 stages to the patient in question.
1) The pre-contemplation stage. This would have been when the patient was engaging in poor oral hygiene, not having any intention of changing.

2) The contemplation stage. This is when the patient would have been making sense of the information I had given her and thinking about the potential consequences of not making the change.

3) The preparation stage. The patient would have decided to make the change and made preparations such as the purchasing of a new toothbrush and floss.

4) The action stage. The patient improved her oral health through improved oral hygiene.

5) The maintenance stage. This is the stage that the patient is now in and which needs to be maintained.

The U.S Department of Health and Human Services (2005, p.5) observe that “No single theory dominates health education and promotion, nor should it; the problems, behaviours, populations, cultures, and contexts of public health practice are broad and varied. Some theories focus on individuals as the unit of change. Others examine change within families, institutions, communities, or cultures. Adequately addressing an issue may require more than one theory, and no one theory is suitable for all cases”. This indicates that when attempting to improve a patients’ oral health there are many factors which may affect behaviour change and these need to be taken into consideration. The Behavioural and Social Sciences Research Branch Centre for Integrative Biology and Infectious Diseases (2007) state that “Current models of health behaviour have difficulty accounting for the multitude of oral health determinants and needs of individuals, families, groups, and communities”.

Evaluating thoroughly the reasons why this patient may have made the change to improve her oral health, has highlighted to me the ways I can improve my oral hygiene instruction to other patients. I realise the need to continue improving my confidence in dealing with people who I may perceive to be unapproachable, I need to continue to take into account the patients different learning styles, and I also need to work on taking patients through the stages of change discussed. In doing this I need to consider each individual situation so that I can target areas that may move a patient from the pre-contemplation stage through to the contemplation, preparation, action and maintenance stage, with the aim to be to raise the standard of oral health for the patient. After a week of applying the research to practice, I feel I have been better able to ascertain potential triggers for a change in oral health habits. I intend to further evaluate this as patients return for their maintenance appointments.
References


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