Mary H. Osborne, Resources

PRACTICE RENEWAL

A Leadership Guide for Dentists

Clinical Covenant: Beyond the Standard of Care

There is a fundamental issue that deals with the standard of care in dentistry which is not often discussed. This is the Clinical Covenant you have with your patients. A *covenant* is very simply an agreement. In this case, it is an agreement you have with the people you serve. But I like the word *covenant.* For me, it represents a ***depth of commitment*** that the word *agreement* just doesn't convey. And a Clinical Covenant refers to what you agree to clinically. You are a clinician. You diagnose clinical symptoms; you make clinical recommendations for treatment; and you provide clinical services. I know sometimes it's easy to lose sight of that with all the other things that are expected of you, such as managing a business, leading a team, and promoting your practice.

But nothing is more important than your Clinical Covenant and the philosophy it represents. ***It is the foundation on which your practice is built and the power that sustains it.*** It is the element that makes your practice unique because it is a reflection of your values, experience, skills, and knowledge. It reflects your passion and your integrity. It must become the hallmark to which you hold yourselves accountable. If the *standard of care* in your practice is about ***what*** you do, then the Clinical Covenant is about ***why*** you do it. The clearer you are about why you do what you do, the better able your team will be to represent it, and the better able your patients will be to understand it.

Sharing the *Why*

Whether you are talking about urgency care or highly elective procedures, there must be a clarity about what goes into your recommendations. I am continually surprised by how little time is spent by most dental teams talking about clinical recommendations when patients are not present.

When I am visiting a practice, often I'll ask a question about why the dentist made a particular recommendation and learn a lot about that dentist in the process. I can't tell you how often people who have been working in that practice for years will say, "Oh, I never knew that." Dentists tell me their teams "know all that stuff." What I find is that they frequently know a lot about the ***what*** and not much about the ***why.*** I believe their abilities to represent your recommendations well to your patients is directly proportional to how well they understand why you made the recom-

mendations in the first place.

Let me be clear. I'm not saying that everyone who works in your practice has to go to dental school. I don't believe they have to memorize clinical studies and the documentation on materials. I'm talking about an understanding of your perspective. Not just your recommendations in ***this*** case, but ***how they fit with every other recommendation you make.*** That's what creates your covenant: what you know, what you take into consideration, what you see as important and not so important, where your biases lie and how they developed. More often than not, your team can learn a lot of that information in bits and pieces over twenty or so years of working with you. But that's a long time to wait for them to be as effective as you'd like them to be with your patients.

Information vs. Meaning

Often in thinking about dentistry, I return to Bob Barkley's book, *Successful Preventive Dental Practices,* written so many years ago. In it, he quotes a book on reflective thinking that says,

> We suddenly discover that what we possess is a conglomeration of patterns, not an integral structure. What appears to be knowledge turns out to be mere information.

How much of what drives your clinical recommendations is mere information? Is it a hodgepodge of procedures accumulated over time? Is it the latest technique promoted by the current guru on the speaking circuit?

Mere information has little meaning for people. It doesn't move them; it doesn't move your patients, and it doesn't move you. In a letter about referrals that I received from a friend, he said that ***your patients refer other people to you for what you mean to them.*** I agree. What you mean to your patients has a lot to do with your relationship with them, and as a provider of clinical services, this has a lot to do with what you stand for.

Now I am not suggesting that you go off to the mountain top and come back with an esoteric philosophy statement that you all feel good about for a few days until you get busy doing dentistry. I am suggesting you begin an ongoing process of breathing life into your clinical recommendations. Stand for something!

Stand for Something

We sometimes wonder why our patients so seldom see our practices as special enough to stay in when they're faced with op-

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tions like more convenient practice location, or whatever. I'd like to suggest that the very things that are innately distinctive about your practice may not even be very clear for those of you who work in it. To encourage the enthusiasm your patients must have to refer to your practice, you must come from a place of enthusiasm and passion for your work.

I believe that passion and enthusiasm come from a deep commitment and belief in the value of what you do. It comes from taking a stand and making recommendations based on your understanding of the best clinical options available. It comes from accepting responsibility as an expert in your practice. Not as an expert in the traditional medical-practitioner-know-it-all model. Not as an expert on your patients, for they know themselves and what's best for them better than you can ever hope to know that. But your patients come to you for your expert opinion on dentistry, and you have a responsibility to provide that.

My dictionary defines an *expert* as "someone with a high degree of skill in, and knowledge of, a certain subject." An expert doesn't have ***all*** the skills and knowledge, or even *more than anyone else*, but he or she does have to have ***a high degree of skill and knowledge.*** You have a responsibility to have that skill and knowledge, and to have the courage to use it to form opinions.

The question, of course, that comes up is, "How much skill and knowledge is enough?" Some dentists and other dental care providers care very little about learning more. Some think they'll never know enough. Certainly somewhere between those two extremes lies a healthy medium. Perhaps what is most important is knowing what you do know and can do well, what you don't know or can't do well, and where and when to ask for help.

Responsibility to Learn & Grow

Frequently, I have the opportunity to interview young dentists for my clients who are hiring an associate, adding a partner, or looking for a dentist who will be successful in taking over their practice when they retire. One of the questions I like to ask them is, "In what areas do you see yourself growing clinically in the next few years?" I can't tell you how often I hear, "Oh I know what I need to know, mostly I just need to pick up my speed."

After many years in dentistry, I've finally come to see the humor in that. They don't know what they don't know. Their naiveté is understandable and even excusable. What I find not so excusable are the practitioners of many years who develop a "Been there! Done that!" mentality which doesn't allow them to look at their work with a different perspective and does not serve their patients well by any stretch of the imagination.

It is not an option for a professional to continue to learn and grow. It is a responsibility. That is true for dentists and for everyone else on the team who sees himself or herself as a professional. You don't have to learn everything. You can choose not to do implant surgery or endo in your practice, for example. But you must know enough to consider them and help your patients decide when and if they are appropriate. I believe you have a responsibility to have knowledge about what is going on in your profession and to be a resource for your patients in regard to what dentistry can offer. And I believe you must encourage your whole team to become involved in a healthy exchange of ideas regarding clinical services.

Healthy Exchange of Ideas

Nothing invigorates a practice like a healthy exchange of ideas about the work you do. All team members who have been involved in discussions and problem-solving about a patient's treatment plan have ownership of that plan, and with that ownership comes investment in its acceptance, commitment to its success, and enthusiasm for the process.

I want to be clear. I am suggesting an active, ongoing dialogue based on real people and real cases. If you have some foundational work to do, it may be appropriate to set aside a couple of days in a retreat type of setting to thoroughly explore foundational principles. But please understand that kind of discussion cannot take the place of an ongoing dialogue about how what you recommend is a reflection of what you believe.

I visited a practice where a patient came in, at the recommendation of the hygienist, to talk with the dentist about improving the appearance of some large anterior composites with veneers. The doctor and I spoke with the woman that day, and our conversation with her became a topic for discussion at the team meeting. As a result of some questions I raised, the dentist and hygienist got into a lively discussion about the treatment being recommended.

During the course of their conversation, the hygienist went back and forth regarding the best treatment for the patient; veneers or crowns. I think it was a wonderful learning opportunity! I learned what the doctor took into consideration in making his recommendations and what questions came up for the hygienist. I learned more about each of their clinical perspectives — what they knew and what they didn't know. And what I realized was that they were learning those things about each other as I was learning about them.

The other thing I noticed was that there was some discomfort for both of them during the conversation. It was somewhat confrontational, and neither of them were very comfortable with conflict. I understand their discomfort. But I believe that stepping out of their comfort zones is exactly what they needed to move forward. That kind of conflict of ideas is healthy and invigorating for a practice. ***Conflict of personalities drains energy. Conflict of ideas creates energy.***

By the way, I know that kind of exchange of ideas is not what any of us in dentistry learned in school. For the most part, we were taught that the dentist formed clinical opinions, and everyone else was supposed to learn what they were, so we could represent them to our patients. Perhaps a hygienist had some say in the perio department. Sometimes a dental assistant was allowed to point out decay the doctor missed during a prep. But by and large, no one was really expected to ***have*** opinions, let alone ***express*** them.

What's interesting to me is that almost everyone I meet in dentistry has clinical opinions. Sometimes they express them openly, and sometimes they do not. Sometimes their opinions are based in knowledge, and sometimes they are not. In any case, I believe those opinions show through in communication with your patients.

I remember when treatment plans in dentistry offered choices between fixed bridges and removable partials, amalgams or crowns, extraction or endo, perio surgery or not, and ortho or not. Dentistry today is much more complex because we have so much more to offer people. It's complex because we're asking our patients to consider what they want, not just listen to us telling them what they need. It's complex because we're not offering people a product they can discard when they get tired of it. We're offering services, procedures, and products which first, must do no harm and be integrated into our patients' bodies, and then must be maintained in order to continue to serve them well. The more clearly those of us who work in dentistry understand that, the better able we will be to encourage dialogue with our patients to help them make healthy choices for themselves.

Developing Your Clinical Covenant

Where do you begin in developing your Clinical Covenant? At the beginning. You might like to begin by asking each person on your team to come to your next team meeting with a written statement of what your practice believes about health. Share what each of you has written, and ask yourselves where the differences are. Don't ask where you disagree because you're not likely to hear conflicting opinions expressed. I'm talking about more subtle differ-

ences, the kind of differences that have subtle effects on your recommendations.

Some of the questions you might want to consider:

- Why are some people healthier than others?
- What contributes to health?
- What detracts from health?
- What are your own barriers to optimal well-being?
- How have you overcome barriers to health in the past?
- What effect do you believe diet has on health? Genetics? Attitude?
- What can you expect from patients in regard to responsibility for health or disease?
- Do you believe dental disease is truly preventable?
- What are the odds of children today growing to adulthood with no dental disease?

Let me give you an example of how these kinds of questions play a role in your practice. I remember a conversation I had many years ago with a periodontist to whom we referred patients. We were discussing various techniques for removing plaque and helping people maintain a healthy mouth. We were in complete agreement about the efficacy of the home care techniques we were discussing, but he tended to recommend surgery more often than we did. When I asked him why, he said that his experience was that while it was possible for patients to remove bacteria from pockets, they rarely had the commitment and/or dexterity to do it effectively over time. That was an important piece of information for me to know about him.

You see my experience had been different from his. Many patients with whom I had worked had made and kept that kind of commitment, and he acknowledged that to be true with many of my patients. We were not debating who was right and who was wrong. We both had legitimate differences of opinion. I respected his opinion because it was based on his observation of hundreds of patients, and he had drawn a reasonable conclusion.

He respected my opinion because it was also based on extensive experience, and it caused him to question his assumptions about everyone. I was able to communicate the differences in our perspectives clearly and honestly to my patients, and they made truly informed choices based on their own knowledge of themselves and the risks involved. They knew they would be supported by both of us regardless of their choices. Everyone was well served.

By the way, he could have just mailed me the studies that would have backed up his clinical perspective. But the truth is that I was referring patients to ***him***, not to some dental journal. Because of his openness in participating in a dialogue with me, my referrals to him were personal, authentic, and confident. What I learned about him was that his recommendations were not founded on profit motives, specialty school training, or the latest journal article. I saw him as an open, thoughtful, knowledgeable clinician willing to take full responsibility for his recommendations and willing to consider the validity of other opinions, even those of a hygienist.

As you discuss what each of you on the team believes about health and disease, you are shaping your clinical philosophy. But so what? ***How does what you believe play itself out in terms of what you do?*** Look at real examples from your practice and your own lives. If you're human, you'll find congruence and incongruence. Great! Let's look at specific areas you might explore.

Information Gathering

Begin with your information gathering process. How much do you feel it is important for you to know about your patients? Look at your health history and ask yourself how you will treat any patient *differently* based on his or her response to each question. I'd like to suggest that if you are not going to do anything different based on their responses, it is better not to ask the questions.

If you ask a new patient about diet and exercise but never talk afterwards about anything but plaque, I think the question is inappropriate. I know it has become fashionable for lawyers to tell us how to write medical histories, but I believe it is our responsibility as clinicians to go *beyond* protecting ourselves from litigation. We must ask appropriate, useful questions designed to help us help our patients become healthier. And we have a responsibility to take what we learn into consideration when recommending and providing treatment.

Another aspect of information gathering is the clinical exam. What do you pay attention to in a clinical exam? I believe our patients have a right to know about any and all conditions existing in their mouths, whether or not we think they want to do anything about it and whether or not we offer a service to do anything about it. Our patients don't pay us to make assumptions about them. They pay us to recognize, diagnose, and communicate what is possible for their dental health, so they can make good choices for themselves.

How did you develop your current clinical exam for new patients and for those in ongoing care? My guess is it may be different from when you first got out of dental school. How has it changed? What have you added? Discarded? Delegated? And why?

For example, I have heard a lot of controversy about what constitutes a thorough periodontal exam. When I ask practices why they do theirs a certain way, the response usually has to do with some course they took or a consultant's recommendations. That's all well and good, but what do ***you*** believe about diagnosing perio disease? Dentists and hygienists have a responsibility to bring their experiences, knowledge, and *opinions* to their patients.

In many practices a thorough periodontal exam is not part of a comprehensive exam. The perio exam is done at the first hygiene appointment because the dentist and hygienist often don't agree on pocket depth measurements. What would it take to change that? Why not schedule some time for the dentist and hygienist to coordinate and calibrate their techniques? Both could learn something. If necessary, invite someone into the practice to help with that process, perhaps a local periodontist or another hygienist who is skilled in the latest techniques.

I believe hygienists should have all the respect they deserve as clinical co-therapists, but a dentist may not abdicate responsibility for periodontal treatment in his or her practice by labeling it the hygiene department's problem. Aside from the obvious legal, moral, and ethical problems with that attitude, think about what it says to our patients about what we believe about the human body: that it is a series of discreet elements not related to one another. Dentists do teeth. Hygienists do gums. But they are connected!

I do believe we communicate something to our patients by what we pay attention to. When the entire dental team is integrated into and takes responsibility for every aspect of your patients' health, your patients are more likely to see their health as worthy of their own attention. And they will see their dental health and well-being as integrated into that big picture.

Diagnosis

That, of course, leads us to the diagnosis aspect of care following information gathering. The way in which you differentiate between health and disease is an element which separates you from other practitioners. I know we would like to believe that this process is objective, but the distinction between health and disease has varied over time, and techniques for diagnosis are changing rapidly.

It is important for you and your team to discuss how you diagnose disease:

- What methods and materials do you use for diagnosis, and which ones have your highest trust?
- How do you determine when to take a full mouth series, a Panorex, or bite wing x-rays?
- How will you determine when it will be appropriate for you to embrace new x-ray technology?

- In what situations will you recommend diagnostic models?

Again, you have developed opinions about those things as have other people on your team. If I worked in your practice, what could I tell people about how you approach diagnosis other than that you are thorough? (What practice would say they were not thorough?)

Treatment Recommendations

The next, and perhaps the most important element, of your Clinical Covenant is treatment recommendation. Any ten dentists who are clinically knowledgeable, ethical, and committed to excellent patient care could conceivably come up with ten different legitimate treatment plans for the same person. Appropriately so! This is where your unique perspective shines through. The clinical modalities, procedures, and materials you use in combination are all a product of your lifetime of learning in dentistry. This is where you are accountable for your unique perspective.

You are not a painting contractor trying to figure out what the market will bear and submitting the lowest bid. You are a professional with an opinion which you have a responsibility to voice and which your patients and other professionals have a right to challenge. The clearer you are about the ***why*** behind your recommendations, the more effective you will be.

I am not talking about justifying or defending your recommendations. It is not your responsibility to convince people to do what you say. You are being asked to give your honest clinical opinion on the opportunities you perceive for your patient to have an enhanced quality of life.

When I started in dentistry, we were primarily a needs-based profession: getting people out of pain, stopping the progress of decay, making dentures so people could eat. I don't think many people in dentistry today see their work in that way or find particular joy and fulfillment in that aspect of dentistry. But somehow our profession tends to cling to that language of *need.* There's a part of us that longs for the good old days of a patient saying, "Anything you say, Doc. I'll do what I have to." We can't have it both ways.

We are in the business of helping people become healthier. Whether that involves eliminating active disease, enhancing someone's appearance and self-esteem, enabling a person to chew comfortably, or empowering children to care for their own mouths with pride and dignity, it's all about helping them attain optimal well-being and health. Our job is to help our patients figure out what they want for themselves and help them see possibilities they cannot see for themselves. And it is our responsibility to tell them what we can do to help them achieve the outcomes they want.

That requires taking a stand. I remember a time when I was practicing clinically, and we were trying to sort out the claims of the current researchers to determine the best way to treat periodontal disease. We went to every perio meeting, heard every speaker who set up a soap box on a convenient corner, and read every article we could get our hands on. What we came to realize is that they all had excellent protocols with data to support their excellent results. And they were all different!

The reason for that was simple: a lot of things work well for some people, and a lot of things don't for other people. No one offered a 100% success rate or any other guarantee. When all was said and done, we had to go back to our practice and offer our patients our best recommendations based on our interpretation of the information, our experience, and our beliefs and values combined with what we knew about each of our patients.

Sometimes we were quite certain that a particular recommendation was best. Sometimes we saw several options that seemed reasonable. We told our patients what we knew, what we didn't know, what we thought, and what we believed. And we respected their abilities to choose what they wanted for themselves based upon our best recommendations.

For the most part, your patients don't want the studies; they want your opinion of the studies. They don't want the specs on the bonding material; they want your opinion of the material, your confidence (or lack thereof) in the material. And you have a responsibility to tell your patients your opinions and also to help your team understand them as clearly as you possibly can.

Delivery of Clinical Services

Finally, we come to the last element of the covenant on which your patients can base their perceptions of your practice and their expectations of you: the delivery of your clinical services. The truth teller.

- Do you deliver what you promise?
- How do you stand behind your work?
- How willing are you to be perfectly honest about your recommendations, the risks involved, the potential for failure — whatever it takes for patients to make a truly informed choice?
- How willing are you to admit when you fall short of perfection and take appropriate responsibility for the outcomes of your imperfections?

I hear a lot of dental practices talking about being the "Nordstrom of Dentistry." Nordstrom is a clothing store which originated here in Seattle and is *legendary* for its excellent service. But before it was known for service, Nordstrom had a reputation for standing behind its products. *Anything* is returnable for a refund at *any time.* Legend has it that someone once returned an automobile tire to Nordstrom's and got a refund, even though Nordstrom *does not sell tires*.

Of course, there are people who misuse that privilege. But Nordstrom didn't wavered in their commitment, and they could thrive when other department stores were failing in the retail market. Nordstrom couldn't buy the reputation and attendant publicity that has grown out of that tire story and others like it. People don't just shop Nordstrom; they believe in Nordstrom. They know Nordstrom can be counted on, can be trusted.

I'm not suggesting you start a 100% guarantee policy and give people refunds for tires you don't sell. But I do believe your patients and your team want to know that you can be counted on. They have a right to know what you will take responsibility for, and what you will not. This may not be in the form of a written guarantee, but in a clear verbal statement as to what you believe in regard to dentistry that fails.

- What will you take into consideration?
- What factors can you control and which ones can't you control?
- What are the *reasonable* expectations for an outcome that a patient may have for one choice over another?

I'm comfortable telling patients I expect the gold crowns in my mouth to last a lifetime. I'm also comfortable telling them I have one that just had to be replaced. That is the reality of dentistry. This is not a perfect world. They don't need to know how much on the dollar you will charge them to replace crowns you have to redo based on how many years they are in their mouths or how many miles they've chewed, whichever comes first. ***Your patients do need to know that if you think you may have in any way contributed to a restoration's failure, you'll say that without hesitation, and make it right.***

If your implants fail 2% of the time, tell your patients that as you tell them how beautiful those implants will look in their mouths. If you'll replace it at a reduced fee if it fails in less than five years, say that. If you want your patients to assume full responsibility for any breakage after they walk out your door, say that. People are capable of taking full responsibility for their choices if they see themselves as making those choices with all the information they need. But they won't be so willing to do that if they feel that they have to watch out for themselves because you are watching out first for yourself.

There is no more powerful persuader than genu-

ine confidence. Ask your team members to write what they believe your policy is about responsibility for dentistry that fails.

One of the most empowering experiences for me as a hygienist was when I knew I did not have to check the chart to see if a failing restoration was done in our practice before I could tell patients a restoration was failing. If it was failing, I could say it. That was the truth. No excuses for whoever did it. If we were responsible, I knew I could say that and patients knew it, and they trusted me if I said we were not responsible.

If your team cannot state very clearly how they believe you stand behind your work, then you likely have a confidence problem that must be addressed. Don't be theoretical in this discussion. Be real. Talk about real cases and specific situations, unless you've never had a failure — yet.

We have discussed the four legs on which your Clinical Covenant stands: Information Gathering, Diagnosis, Treatment Recommendations, and Delivery of Services. As you discuss each of these areas on an ongoing basis with your team, it is entirely appropriate to include, among other things, your beliefs, knowledge, values, experience, intuitions, and insights. Those are the things that make you who you are and have a legitimate role to play in shaping each of the four elements we have discussed.

Elements to Avoid

I'd like to talk briefly about some of the issues that should *not* have a place in this process.

- ***Our Egos:*** We must get our egos out of the way if we are to create an atmosphere of intellectual exploration. Even when staff members question your most cherished assumptions, you must open yourself to other possibilities and perspectives. Of course, the spirit of true discovery and respect must exist for team members as well. This isn't an exercise in second guessing and asking the dentist to justify recommendations. If you have concerns about your ability as a team to maintain that spirit, you may want to have someone facilitate this process.

- ***Our Judgments:*** Someone said the only stupid questions are the ones that don't get asked. You may be surprised, and even disappointed, at the level of understanding of dentistry some of the people who work in your practice may have. Do not assume anything about what they know. They may not even know what they don't know, so they won't always know how to ask questions.

  My experience is that there are gaps for most of us in our knowledge of dentistry. For example, there is frequently a lot about dentistry hygienists don't know and a lot about hygiene others in dentistry don't know. And there's a history in the profession of not wanting to appear uninformed. So it may take encouragement for your team members to ask their questions.

- ***Our Fears:*** Our fears have no place in this process. Our concerns about image in the dental community, our fear of rejection, or of being seen as greedy — all have no place here. You have a right to any and all of those fears, but you don't have a right to allow those fears to cause you to offer less than what you believe to be the best treatment for each patient.

- ***Our Issues About Money:*** Our money issues have no place in this process. It's unfair for us to make assumptions about what our patients are willing to pay for. Our need to fill an hour in tomorrow's schedule doesn't justify a recommendation for one crown when we could take the time to help a patient see a bigger picture and plan for the future

- ***Our Assumptions:*** Our assumptions about patients have no place in this process. We must be open to their abilities to grow and change, to be open to something different from what they were open to six months ago, six weeks, or even six days ago. We have no

right to assume what they are capable of, what they are willing to do, or what they can understand.

- ***Our Overblown Sense of Responsibility:*** We must know where we end and where our patients and team begin. We must be clear on who owns the problem and what we can and cannot do to help patients become healthier. We must be willing to allow patients the ownership of the outcomes they have created without judgment or blame. We have no right to deprive patients of the lessons they learn from their choices or to rescue people who haven't asked to be rescued.

- ***Our Control Issues:*** Control issues have no place in this process. Controlling behavior, a need to be right, and a need to have things come out the way we want them to, all have the potential to shut down a team's healthy process and a patient's healthy curiosity.

- ***A Good Ol' Boy (or Girl) Network:*** When making recommendations for treatment outside of our area of expertise, we have a responsibility to recommend the most competent specialists we know to provide those services, not the one who just gave us Rose Bowl tickets. Patients have a right to expect that we know something about the values, knowledge, and competence of the people to whom we refer. They have a right to expect us to know our own limitations in order to know when to refer. The relevant question to ask once you are clear what you will recommend is, "Can my patient get that service somewhere else with a higher probability of success and/or ease?"

There is so much more I could say about the Clinical Covenant. But what I really want you to hear is that these are exciting times in dentistry. We have so much more to offer people than we have ever had before. And each dentist and dental team has their own unique contribution to make to their patients and to the profession as a whole.

The single biggest difference I see between practices that grow and thrive and those that limp along is a collective enthusiasm for the services they provide. In Bob Barkley's *Embryonic Philosophy* written in 1964, he stated, "A philosophy is governed by your belief that your care is as important to a patient as any other thing on which they can spend their money."

Make your Clinical Covenant live in your practice. Talk with your team about what you believe — not once a year, but with every case you treatment plan. Talk with your patients about what you believe — not just about what you recommend, but ***why you would want it for them.*** And stand behind your recommendations with acceptance of responsibility for your failures and pride in your successes.

Classic & Current Resources

My work is influenced and informed by the wisdom of past as well as emerging new thinking. The following is a list of some of the sources I referred to while writing this issue of *Practice Renewal:*

American Heritage Dictionary

Embryonic Philosophy by Bob Barkley

Successful Preventative Dental Practices by Bob Barkley

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Clinical Covenant

1. How much energy do you devote to learning and growing clinically in your practice? How much does your practice culture promote and expect learning and growth of all team members? How can you encourage and role model more growth?

2. How do you currently promote a healthy exchange of ideas in your practice? How can you create an environment of greater safety and openness to share and discuss differing clinical opinions and perspectives?

3. ***Creating Your Clinical Covenant, Part 1:*** Ask each team member to come to your next team meeting prepared with a written statement of what your practice believes about health. Share what everyone has written and ask yourselves where the differences are. Use the questions on page 5 for further discussion. Distill the resulting discussion down into a single written statement about what your practice believes about health.

4. ***Creating Your Clinical Covenant, Part 2:***

   - ***Information Gathering—Health History:*** How do you actively use the information you collect on your health histories?

   - ***Information Gathering—Clinical Exam:*** How did you develop your current clinical exam for new patients and for those in ongoing care? How has it changed since you began practicing? What have you added? Discarded? Why?

   - ***Diagnosis:*** What methods and materials do you use, and which ones have your highest trust? How do you determine when to take a full mouth series, a Panorex, or bite wing x-rays? In what circumstances do you recommend diagnostic models?

   - ***Treatment Recommendations:*** What do you stand for? How have your experiences, interpretations, beliefs, and values led you to your current recommendations?

   - ***Delivery of Clinical Services:*** What do you take into consideration in terms of standing behind your work? What factors can you control and which ones can you not control? What are reasonable expectations for the outcome from a particular restoration or other procedure?