Change

Annual Review
2015

Dental Protection

www.dentalprotection.org

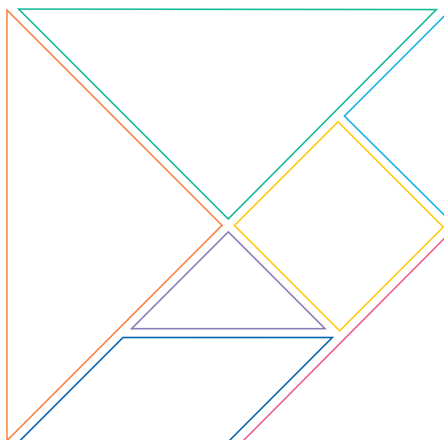
Contents

Reports 2–5
Who's who 6
Keynote articles 7–19

Change in the external environment 20–24
Changes within healthcare 25–32
Changes within the dental profession 33–37
Changes within clinical dentistry 38–42
Changing the patient's self-image 43–46

About your membership 47–57
Professional development with Dental Protection 58–59

Contacts 60–61



Tangrams
The illustrations in this year's Annual Review are based on the traditional pieces used in the Chinese tangrams puzzle (literally: "seven boards of skill"). The puzzle consists of seven flat shapes, called tans, the arrangement of which is changed to create a recognisable, but different silhouette. The original colours of the pieces have been adapted to match the design palette used on our recently updated website.

The objective of the puzzle is to form a specific shape (given only an outline or silhouette) using all seven pieces, which may not overlap. Over 6500 different tangram configurations are known to exist.

The puzzle was invented in China during the Song Dynasty and then carried overseas by traders in the early 19th century.

PRISM
Dental Protection members can obtain verifiable CPD after reading selected articles from this publication via the online e-learning portal - Prism. The word **PRISM** at the foot of a page is used throughout the *Annual Review* to denote the available CPD articles.

www.dentalprotection.org/prism

Dental Protection Limited is registered in England (No. 2374160) and is a wholly owned subsidiary of The Medical Protection Society Limited (MPS) which is registered in England (No. 36142). Both companies use Dental Protection as a trading name and have their registered office at 33 Cavendish Square, London W1G 0PS.

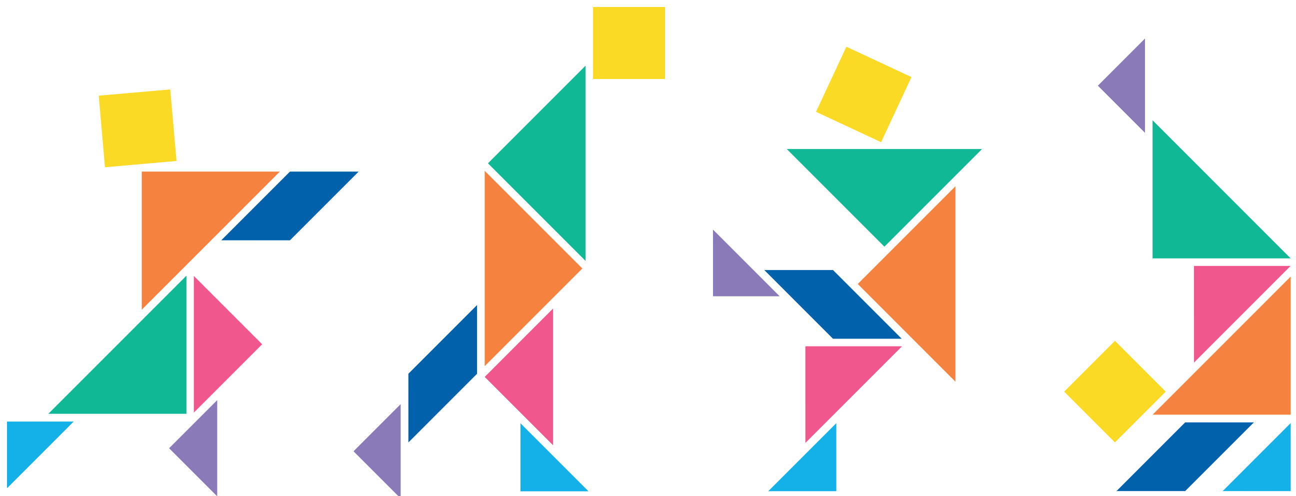
Dental Protection Limited serves and supports the dental members of MPS with access to the full range of benefits of membership, which are all discretionary, and set out in MPS's Memorandum and Articles of Association.

MPS is not an insurance company. Dental Protection® is a registered trademark of MPS.

Change

Dentistry does not stand still

Over its long history, dentistry has shown itself to be a continually evolving profession, and one which has been quick to grasp and embrace new ideas, new technology and materials in order to enhance the range and quality of the care and treatment provided to patients.



Dental training has changed at both undergraduate and postgraduate level, and so have patient expectations and their relationship with all of the health professions. Both of these factors focus attention upon the standards expected of dental professionals and the way in which the various healthcare professions are being regulated.

The speed and scale of all this change has been greater in some countries than others, and this disparity has coincided with a greater movement of both patients and dental professionals around the world. The convergence of these factors onto a collision course is reflected in many of the cases which Dental Protection deals with internationally, and this trend shows no sign of abating.

But dentistry does not exist in isolation from the world in which we find ourselves, and nor is it immune from the pressures and challenges of a world which is in a state of such political, economic and social flux.

There can surely never have been a period over which the pace of change and the multiplicity of challenges has been greater, than in the period since the turn of the millennium. This has consequences for us all – what happens to us, what we do, how we think and how we feel.

This year's Annual Review encourages us to pause in the face of so much change, and to consider what it all means for us and how it is affecting us and our professional lives.

Chairman's report

The theme of this year's Annual Review – "Change" – is very timely, and just as applicable to Dental Protection itself and the whole of the Medical Protection Society (MPS) group of companies, as to any of our members individually anywhere in the world including me.

New role

My recent arrival at Dental Protection and MPS may be seen as part of the process of change. I was very conscious of the international status and achievements of the company as well as those of my illustrious predecessors when I proudly accepted the position as Chairman of Dental Protection Ltd (DPL) in 2014, upon the retirement of Professor Trevor Burke. Trevor and I had worked together in my earlier career in Glasgow and so I know the qualities of the man. Therefore, in succeeding him, I have taken on the Chairman's role with a sense of joy and excitement, and a little trepidation!

I have spent several years of my career working in the area of professional regulation and, more recently, as a member and Chairman of various committees within the Fitness to Practise procedures at the General Dental Council (GDC) in the UK. I have learned a lot about the good, the bad and the ugly of healthcare regulatory processes and I have already come to appreciate how useful that experience will be in my role at Dental Protection and as a member of the Council (Board of Directors) of MPS.

Healthcare regulation is a red hot issue for professional groups in many of the countries where we work and a "live" and painful issue personally for those who are under investigation by their professional regulator. During the years I spent on Fitness to Practise at the GDC, I also witnessed firsthand just how Dental Protection cares for its members and supports them through the most difficult of times.

Working in education

In my "day job" as a clinical academic, I am very much a part of another area of significant change – not just within tertiary education itself, but also at the crossroads of increasing financial pressures on one side, increasingly prescriptive curriculum direction on another, and the imperative to maintain standards while also producing the next stream of graduates ready, fit and able to step safely into the front line of healthcare delivery. The less obvious but very real challenge for educators like me is that the students themselves have changed, the technology has changed and the world in which they live has changed. Many of these fascinating themes are picked up in the pages of this publication.

Another area of interest for me is the multicultural dimension of healthcare and its delivery, so the added attraction of finding myself working in an organisation with over 300,000 members on five continents, was irresistible!

The Board

The other new addition to the DPL Board since last year's *Annual Review* reached you, is Professor Callum Youngson, who is the Head of the School of Dentistry at Liverpool University and an Honorary Consultant in Restorative Dentistry, as well as being the Chair of the Dental Schools Council for the UK. Callum and I have joined an experienced, diverse and highly capable Board that is unstinting in its commitment to the dental members of MPS who are served and supported by Dental Protection.

As a Board we advise MPS on all matters relating to the interests of dental members, and we also exercise powers of discretion delegated to us by MPS Council is respect of cases in which dental members are involved. As a newcomer to this Board I quickly became aware that its members are all highly respected leaders in their respective areas of dentistry, including general practice, and you can be reassured that they care very deeply about the dental members of this organisation and the wider dental profession. You will be pleased to hear that this is one thing that *won't* change!

Looking ahead

But, it seems that change is, for the most part, a daily challenge for all of us, whatever the branch or specialty we work in. There have been some major changes in the organisation of dentistry in recent times and who knows what further changes may lie ahead? The 35th president of the USA, John F. Kennedy, once said: "Change is the law of life. And those who look only to the past or present are certain to miss the future."

As the Board of DPL, we look to the past for some aspects of wisdom and we consider what challenges are currently before us. However, most importantly, we keep an eye to the future so that we can, wherever possible, be ahead of the game strategically and in leadership. That way, we hope to serve you, as the dental members of MPS, in the best possible way – today and in the future.

In these tough and changing times, I sincerely hope that you are finding fulfilment in practising the art and science of Dentistry and, most importantly of all, finding delight in serving the patients in your care. May that never change!

Professor John Gibson
PhD BDS MB ChB FRCP(Glasg) FDS(OM) RCPS(Glasg) FFDRCS(Irel) FDSRCS(Ed)
Chairman

Director's report

Exactly 100 years ago, Woodrow Wilson was at the mid-term point in the first of the two terms that he completed as the US President. Less than three years after all that frenetic activity and stress he was dead – a lesson for us all to note. His presidency had spanned the First World War and the ensuing Treaty of Versailles, to which we are told he brought a moderate and insightful voice.

He seems to have been an idealist but also an enigma – lobbying passionately for a League of Nations while never taking the US into it, founding the Progressive Party and yet maintaining American neutrality in the First World War, and yet still having the courage and tenacity to take on and restructure the federal banking system.

He knew a thing or two about change, and attitudes towards it, as clearly illustrated by his much-quoted observation:

"If you want to make enemies, try to change something"

Perpetual motion

This year's Annual Review is in one sense the product of change, while at the same time a reflection and commentary upon change and a toolkit for understanding and coping with change in the dental professional environment. In fact it goes well beyond that and helps us to see that we, like the planet on whose surface we sit, are in a state of perpetual motion whether we like it or not.

The prospect of change, the experience of change, and how people react in times of change, reveals the full panoply of human psychology and behaviour. Dental Protection witnesses that at first hand on a daily basis, but what makes our field of work particularly fascinating is the realisation that none of us is ever completely in control of our destiny. Lurking on tomorrow's day list are patients, procedures, events and complications that can impact upon us and others long into the future.

Managing risk

Dental Protection has a passionate belief in risk management - a relentless search for ways to secure as much control as we can over events, so that members have the best possible chance of staying safe and successful as their professional career unfolds. The irony is that much of what we suggest requires members to be willing to change and embrace new ideas, long before the event that might make the need for that change understandable.

We aim to be supportive and empathetic – a trusted partner throughout your career – but in order to avoid repeating the mistakes of the past we must all be willing to learn and change. That applies to Dental Protection itself, as well as the 64,000 or so dental health professionals who look to us and rely on us in times of difficulty or uncertainty.

The beauty and opportunity of risk management is that each of us can learn from the experiences of others – all over the world – without having to go through the pain of enduring the experience ourselves. This is one of the many benefits of Dental Protection's international presence and experience.

Always willing

One of the recognised hallmarks of this organisation is our willingness to fight important points of principle on behalf of our members – both individually and collectively. We are resolute and tenacious advocates for what is right and fair, and it is important that claimant law firms, regulators, governments, and others are reminded of that. 2014 was a year of many significant successes of this nature, and more followed regularly in the early months of 2015. That will not change.

You will be pleased to know that this shared commitment can be seen at all levels in the Dental Protection team, from my senior management colleagues, to the 70-strong team of dento-legal advisers in our UK and Australian offices, and not forgetting our marketing and secretarial teams and those who carry out other key functions in the course of our work on behalf of members. Their collective knowledge and experience, skill and commitment is outstanding and something with which I am very proud to be associated.

Thank you

I welcome this opportunity to thank each of them publicly for their personal contribution to another successful year for Dental Protection, together with all our locally-based advisers, lawyers and barristers, consultants and valued experts. Thanks also to our many Scheme of Co-operation partners and the organisations and individuals with whom we work so closely around the world.

Smarter working

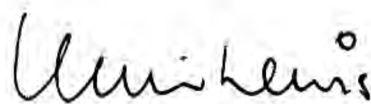
We are dealing with record numbers of cases, providing more support to more members in more ways than ever before. We too are changing the ways in which we work, and actively seeking the benefits of new emerging technology – one small but visible illustration is our new website and its ease of access from tablets, phones and other hand-held devices as well as PCs, but that is only the beginning.

The escalation in the number of requests for assistance is truly extraordinary, but ultimately meaningless, because these statistics matter a lot less than how well we do in the face of that volume of work, and how well supported and cared for the individual members involved are feeling. Fortunately our surveys tell us that we are doing very well indeed but we have ambitious plans to do even better in the year ahead.

Shared vision

Finally, I must thank every member of the DPL Board of Directors for their unflinching commitment and support over the past year. Steering a safe course through the turbulent waters of change is never easy, but it is made more manageable by having the bright light of a shared vision and shared values to guide the way.

We warmly welcome John Gibson as the incoming Chairman of this organisation in which we all believe so passionately, and in doing so we can all be confident of further successful times ahead.



Kevin J Lewis
BDS LDSRCS FDSRCS(Eng) FFGDP(UK)
Dental Director

Who's who

Board of Directors

Professor John Gibson PhD BDS MB ChB FRCP(Glasg) FDS(OM) RCPS(Glasg) FFDRCS(Irel) FDSRCS(Ed)
Chairman
Appointed July 2014

Professor Kay-Tee Khaw CBE MA MB BChir MSc FRCP FFPHM FMedSci
Chairman of Council, MPS
Ex officio

Serpil Djemal BDS FDSRCS(Eng) MRD RCS(Edin) MSc

Sue Greening BDS DCDP

Garry Heavey BDentSc DipClinDent FICD

Peter Hodgkinson BDS DGDP(UK)

Simon Kayll BA MBA FICA
Chief Executive, MPS

Davinderpal Kooner BDS LDSRCS DGDP(UK) MGDSRCS

Charles Ormond BDS MGDS RCPS(Glasg)

Professor Callum Youngson BDS MRDRCS(Edin) FDSRCS(Edin) DRDRCS(Edin) DDSc(Rest Dent) RCS(Edin)
Appointed November 2014

Dental Director

Kevin J Lewis BDS LDSRCS FDSRCS(Eng) FFGDP(UK)

Head of Dental Services

Susan Willatt BDS MBA LLM
Secretary to Board of Dental Protection

Communications Manager

David J Croser BDS LDSRCS MFGDP(UK)

Director of Educational Services

John P Tiernan BDentSc BA DGDP(UK)

Senior Dento-Legal Advisers

Sue Boynton BDS FFGDP(UK) LLM

James Foster BDS MFGDP(UK) LLM

Stephen Henderson BDS FFGDP(UK) LLM

Helen Kaney BDS LLB Dip LP FFGDP(UK)

Jane Merivale BDS LLM

Alasdair McKelvie BDS LLM

Brian Westbury BA BDS LDSRCS MGDSRCS LLM

Senior Dento-Legal Consultants

Alan M Cohen BDS LDSRCS ACIArb

Andrew Collier BDS LLM

Brian D Edlin BDS

Hugh Harvie BDS FDSRCS(Edin) FDSRCPS(Glasg) FFGDP(UK) Dip For Med

Raj Rattan MBE BDS MFGDP(UK) PgDip MDE FFGDP(UK)

Head of Underwriting Policy (Dental)

Michael C Clarke MPhil BDS DGDP(UK)

Dento-Legal Advisers

Janet Barnes BDS MDSc

Charlotte Boyd BDS

Caroline Chapman BDS LLM

Leonard T D'Cruz BDS LDSRCS MFGDP(UK) LLM PGC MedEd Dip FOd

Julia Densem BDS LDSRCS PgDL LLM MA

Martin Foster BDS MPH DipHSM

Richard Hartley BDS MFGDP(UK) MEd LLM

David Hartoch BDS MFGDP(UK)

Joseph Ingham BDS LLM

Ravi Rattan LDSRCS PgDip DPM

Lynn Rees BDS DGDP(UK) LLM

Susie Sanderson OBE BDS FDSRCS(Eng) FFGDP(UK) LLM

Alan JS Seaton LDS

Phil Shaw BDS LDS DGDP MGDS DPDS LLM

Yvonne Shaw BChD DPDS LLM

Terry Simpson BDS LDSRCS DGDP(UK) MSc

Barry Tiernan BDentSC BA

Stephanie Twidale TD BDS DGDP(UK)

Dental Complaints Manager

Sarah Cree

Zoe Wray

Senior Cases Consultant

Michael L Butterworth BDS DGDP(UK) MFDS(RCS) LLM FICD MCIArb

International Dento-Legal Adviser

Nancy Boodhoo BDS FDSRCS

Associate Dento-Legal Advisers

Geoff Baggaley BChD DGDP(UK)

Jasdeep Baydal BDS PGCMDE PGCDLE

Amanda Biddle BDS MSc FDSRCS MRDRCS(Eng)

Elaine Cook BChD

Raj Dhaliwal BDS

Caroline Dodd BDS LDSRCS MSc

Ian Gordon BDS DGDP(UK)

Jane Griffiths BDS LDSRCS PGDCDLE

Sarah Harford BDS

Lesley Harrison BDS MFGDP(UK)

Russell Heathcote-Curtis LDSRCS

Peter Hodgkinson BDS DGDP(UK)

Jill Jagger BDS DGDP(UK)

John Kocierz BDS

Neena Manek BChD MFGDP LLM

Adrian Millen BDS DPDS

Bernice McLaughlin BDS

David Monaghan BDS MPhil

Michael Morris BDS MFDS

Nikolaus Palmer BDS MFGDP(UK) PhD FDSRCS(Eng)

Shiv Pabary BDS DGDP(UK)

Shreeti Patel BDS DGDP(UK)

Andrew Paterson BDS FDSRCPS(Glasg) DRDRCS MRDRCS

Sudhir Radia Stat Exam MFGDP(UK) DPDS(Brist) FFGDP(UK) MGDS RCS(Eng)

Simrit Ryatt BDS

Helen Sayer BDS

Bernard Swithern MFGDP(UK) BDS

Lesley Taylor BDS LDSRCS

Martin Valt BChD MSc MSurgDent DipConSed MFGDP LLB

Claire Walsh BDS DipFMS MML

Alison Williams BDS DDPHRCS MCDH FDSRCS FDS(Orth)RCS

Martin Woodhead BDS LDSRCS

Jane Woodington BDS

Claims Advisers

David Hards

Martin Beaumont F Inst L Ex

Jason Priston F Inst L Ex

Dento-Legal Assistants

Lawrence Currie BSc

Amita Gungaram BA LLB BPTC

Dento-Legal Advisers

Australia

Dr David Evans BDSc FICD

Dr Annalene Weston BDS MHL

Dr George Lazaridis BDS

Dr Mike Rutherford BDSc BA

Dr Ralph Neller BDSc BBus FICD FADI FFP

Israel

Dr Mark H Casson BDS FICD

New Zealand

Dr David Crum BDS Dip Clin Dent FICD FADI

Dr Paul Scott BDS Dip Clin Dent FRACDS FADI FICD

Hygienist and Therapist Advisers

Australia

Vicki Biddle

United Kingdom

Carole Collins DDH

Marina Harris BSc DDH LLM

UK Dental Advisory Panel

Meredyth C Bell MBE BDS MFGDP(UK)

Jennie Gallagher BDS FDS DDPH MSc

Brian Grieveson BDS MFGDP(UK) MGDSRCS

David Harris FDSRCS LRCP MRCS FICD

Roy Higson BDS DGDP(UK)

Christopher Holden LDSRCS DGDP(UK)

Christopher JR Kettler BDS MOrthRCS

John Kocierz BDS

Jim Lafferty BDS

Dame Margaret Seward DBE BDS MDS FDS MCCD DDSc DDS FDSRCS FDSRCPS

Derrick R Willmot BDS FDS MOrthRCS DDOrthRCPS PhD

Australia Dental Advisory Panel

Dr John R McNamara BDSc MDS FICD FADI FPFA *Chairman*

Dr Roderick H Brilliant BDSc FICD FADI

Dr Stuart Gairns BDSc MDSc FADI FICD FPFA

Dr Cosimo Maiolo BDS MDS

Professor Frank NT Monsour AM RFD RFD BDSc MDSC PhD FRACDS FADI

Dr Janet F Scott CSC BDS MDS BScDent (Hons) FRACDS FICD

Dr David G Sykes BDS MDS LDSRCS FRACDS MRACDS(Pros)

Dr Tim S Wigmore BDS MDSc

Ireland Dental Advisory Panel

Dr Jane Renehan MDentSc MBA
Chair

Dr Patrick J Byrne BDS(NUI) MSc FDSRCS(Ed) FFDRCSI

Professor Stephen R Flint MA PhD MBBS BDS FDSRCS(Eng) FFDRCSI(OMed) FICD FTCD

Dr Garry Heavey BDentSc Dip Clin Dent FICD

Dr Ryan Hennessy BDentSc BA

Dr Martin Holohan BDS(NUI)

Ms Susan Johnston RDH

Professor Gerard Kearns FDS FFD FRCS

Young Dentist Representatives in Australia

Dr Rachel Pino BDS

Dr Andrew Wong BDS

Keynote articles

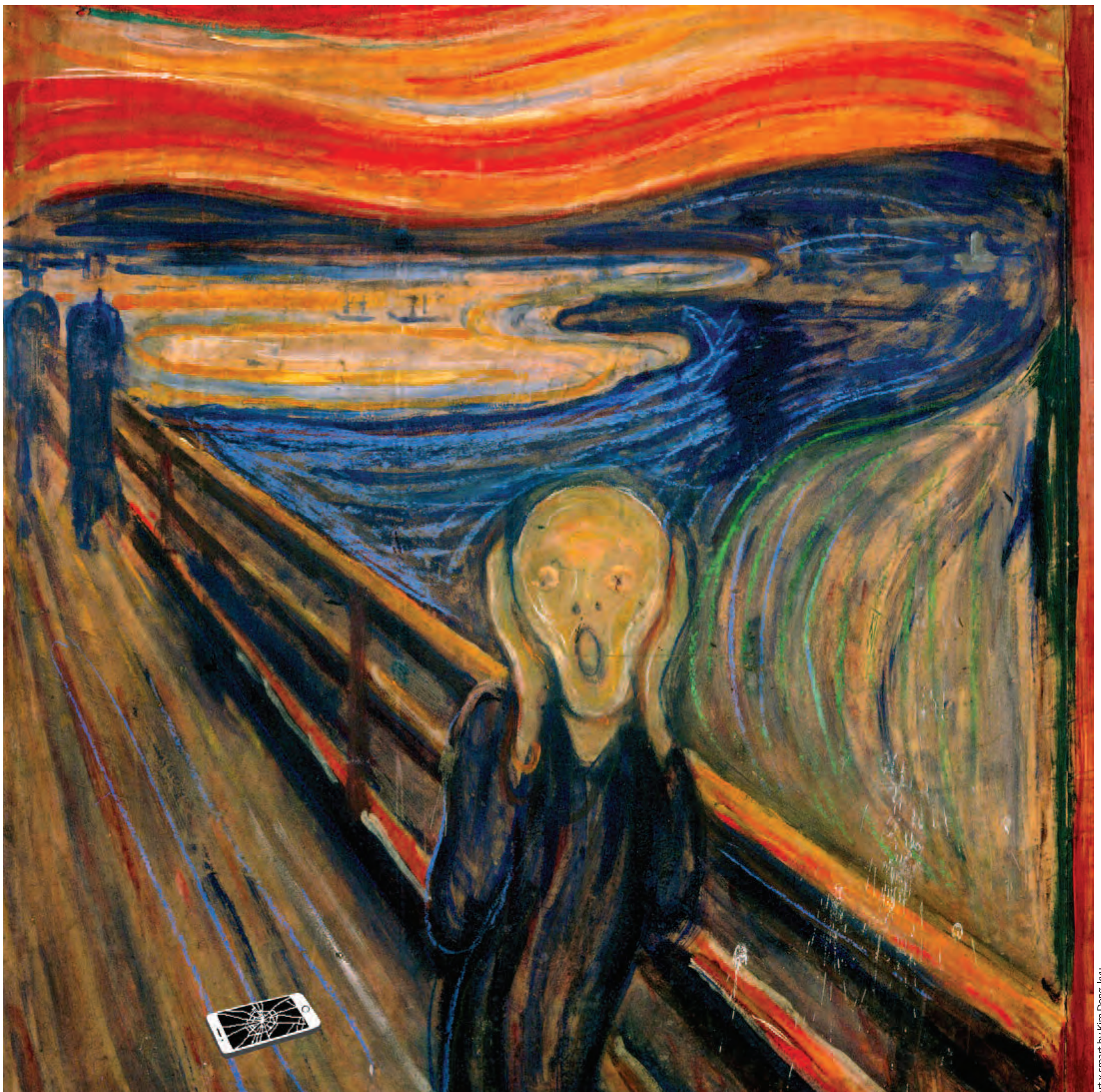
The digital dentist 8–11
The empowered consumer 12–16
Complexity in clinical practice 17–19

The digital dentist

Dentists, digitisation and the demographics of change

Dr Paul Redmond

For today's Facebook generations, "*The Scream*" by Edvard Munch must be one of the most recognisable works of art from the 19th century. Since it was first exhibited in 1893 the image of that elongated head, the agonised expression, the gaping mouth and the haunted eyes – to say nothing of the swirling apocalyptic sky - has been one of the art world's most enduring images, adorning everything from tea-shirts to tea-towels. It's even appeared in the movies. Guess which famous painting child star Macaulay Culkin was parodying in the poster for the 1990 movie *Home Alone*?



Art x smart by Kim Dong-kyu

Although Munch was often vague about the painting's meaning, critics have generally cited a typically modernist preoccupation with loneliness and alienation. It therefore came as a shock when in 2013 *The Scream* was treated to a 21st century make-over. Thanks to a South Korean artist named Kim Dong-Kyu, we might finally know what Munch's man of misery is looking so down in the mouth about. He's broken the screen of his iPhone.

The sound of breaking glass

Taking a selection of famous paintings by Picasso, Degas and Van Gogh, Kim Dong-Kyu added iPhones, iPads and other 21st century communication devices into the famous artistic scenes. The effect is dramatic. Well-known 19th century images are brought suddenly and startlingly up to date.

In Kim Dong-Kyu's version we see the same screaming figure but alongside him there lies a broken iPhone, its glass horribly shattered. Suddenly all becomes clear. It's not *The Scream* that we're looking at, but *The Screen*.

At last we know why the figure is screaming. He's wondering how he's going to get through a day without Snapchat.

> "Last Wednesday, I stupidly dropped my iPhone in the bath, and my life has sort of spiralled almost out of control"

Sir Patrick Stewart (Actor; Captain Picard in Star Trek)

Dentistry and digital communications

For dentists, the ubiquitous nature of the mobile technology that we all carry around with us – and find increasingly traumatic to be without - is of major significance.

Dentistry has a long and proud history of adapting to the political, economic, social and technological context in which it operates. But as with other professions, dentistry is being challenged by the rise of new digital communications. Social media is leading a revolution in how dentists communicate and market their practices. New generations of employees are demanding increased levels of career development and support. Patients, armed with up to date comparative data, are unwilling to accept anything but the optimum levels of customer service. The threats and the opportunities for dental practitioners have never been greater.

For the past decade I have been researching the impact of digital communications on different social generations. In this article, I want to explore some of the findings. My aim is to help you understand not only how digitisation is changing the way that dental patients behave, but may even be changing the way that they think about their lives. In particular, I want to argue that the type of digital communications that we daily interact with is anything but neutral – with potentially profound consequences.

> "We used to run courses to bring students up to speed with the technology at the University. Now we run courses for staff to bring them up to speed with the technology that the students bring in with them in their pockets"

University IT manager

The digital revolution

Although at times it might not feel like it, we are living through a revolution – a digital revolution. Like all those who find themselves living through extraordinary times, it is easy for us to become acclimatised. But don't let this fool you. There is nothing normal about the 21st century.

Consider this. Since being launched in the 1990s, it took the internet just four years to accrue 50 million users. To put that in context, it took the television 13-years to achieve the same level of coverage. And it took the radio, 38 years. The internet is easily the fastest growing communication medium of all time – and by far the most convenient.

Twenty-five years after its invention and one-in-five of the world's population is now online – that equates to roughly one *billion* people. Such saturation has changed forever the way that we communicate with other people. Take for example email. The first email was sent in 1971 by Ray Tomlinson, a US programmer. To signify that the email was being directed to a person rather than a machine Tomlinson used the "@" symbol. He could have chosen any symbol he wanted because the idea quickly caught on. This year, every day, approximately 250 billion emails will be sent. Of these, 200 billion will be spam.

The internet has also changed forever the way we access data. There are now 637 million websites, with 4,200 new domain names registered every hour (equating to 37 million per year). Not that today's internet is just about web pages. Each month over a billion people watch videos on *YouTube*, averaging four hours of viewing per month. The statistics are mind-blowing. Seventy-two hours of video are uploaded to *YouTube* every single minute, and *YouTube's* copyright checking software scans over 100-years of video every day.

But technology is not neutral. Every new communication innovation, from the printing press to the digital telephone, changes the way we think about ourselves and our relationship to the world. It alters what we see as possible, acceptable, and normal. What is particularly remarkable about the digital revolution is how it is rapidly transforming the way that we think.

Digital babies

In the West, the average age at which a child first appears on the internet (think of it as its digital birthday) is six months old. This is usually because its parents have emailed pictures of the new-born to friends and family. There's also a good chance that they will have posted photos of the new arrival online via social media. In many cases pre-natal scans will have made their way to the internet, meaning that even before birth many of today's children have registered a web presence.

The influence of the internet on children's lives doesn't stop with online images. Babies' names are increasingly influenced by online factors, such as the availability of a name-related URL address. It's unlikely that today's children will think anything odd about this. Internet technology is for them, all they have ever known. In the purest sense of the word, it's not even "technology". According to the author Douglas Adams, if a technology existed before you were born, officially, it's not 'technology'. It's just... "stuff".

Not that the prospect of digital babies should be all that surprising. After all, how do you think the baby got here in the first place? Not only is the internet the greatest communication medium in the world; it also happens to be the greatest matchmaker. Nineteen per cent of today's married couples met and fell in love online – and the percentage is rising.

Driving this headlong rush to the internet is social media. Facebook has an estimated 1.2 billion users – meaning that 17 per cent of all humans (or half of all internet users) are registered on the social media site. Even more remarkable has been the growth of Twitter. Founded by Jack Dorsey as an SMS-based social network with the codename "twttr", the first "tweet" was posted on 21 March 2006. Over 1,700 tweets are now uploaded every second.

Love it or hate it, social media is the greatest single example of how the internet is evolving. In the 1990s, the internet was all about static data – often presented in text-heavy, uninspiring web pages.

Then there was "Web 2.0". Gradually, the internet became interactive. Users were invited to think of it as a two-way conversation. You didn't just passively read the internet; you used it as a means to communicate, to record your thoughts, memories and ideas. Sites such as Amazon and Google applied complex algorithms to present users with data that appeared ranked according to their likes and dislikes.

Gone were the days when the internet was the equivalent of a large, dreary department store. Now it was your personal shopper, presenting you with your own unique online odyssey.

The internet of things

The term "internet" no longer applies exclusively to computers. An "internet of things" is rapidly developing, in which anything from heart monitors to car pressure values are assigned IP addresses and given the capacity to transfer data over the internet. Even clothes can now be purchased which attract and retain Wi-Fi signals.

So what does all this mean for us – the users?

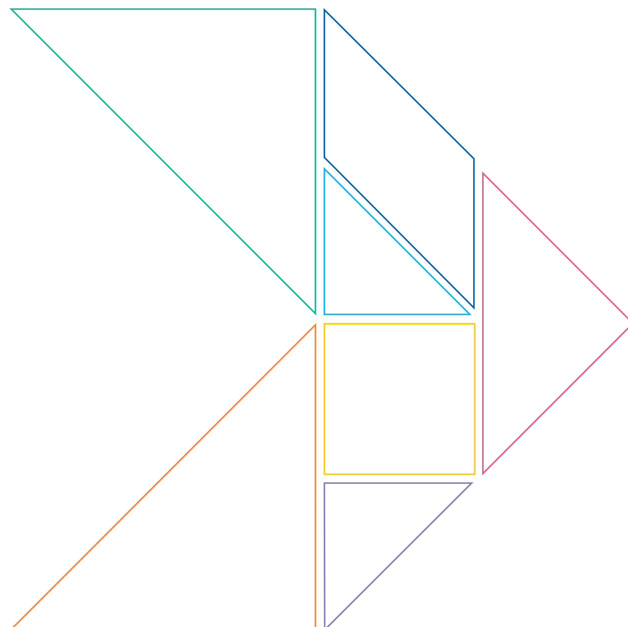
Where everybody knows your name

The impact of digital communications on human behaviour is only now becoming apparent. A life spent on line is not without its consequences. As digital natives, today's young people will never know what it is to be without the internet, without a computer, without a smart phone, without Facebook. For them, they will never know what it means to be anonymous, to be able to construct and reconstruct their own identities.

They will never be lost, never beyond the digital reach of family and friends. Nor, regardless of how successful and eminent they become in their careers, will they be able to escape the digital "back story" of their previous errors, false starts and failed relationships. Everything about them – everything they have ever done or been - will be available all the time to everyone.

Today's generation of young people are also destined to spend an incredible amount of time in cyber-space.

It is reckoned that people who use social networking sites such as Facebook and Twitter will use 10 per cent of their entire life time on these sites. For them and millions of others, reality no longer means things experienced in the "real" world, but a digital narrative constructed on the internet for others to share. This may explain why Snapchat is so popular with teenagers: it's not the experience of the moment that counts, but the story that is posted second-hand on the internet. The question is: what is this doing to our brains?



Forget it! Why your memory is already obsolete

When the portable calculator was introduced in the 1970s, parents and teachers fretted that children would eventually lose the ability to understand mathematics. They needn't have worried. By freeing children up from the tedium of routine calculations, calculators actually enabled young people to gain a deeper understanding of more complex mathematical processes.

Unfortunately, the internet has exactly the opposite effect. By presenting us with a never-ending array of mental stimuli, the internet trains our brains to be distracted, to process information quickly and efficiently but without enough sustained levels of attention to bind that information deep into our memories. The internet trains our brains to be very good at forgetting things, of being able to graze permanently on half-recalled, half-understood information.

"Television and computers are crutches for your attention. And the more time you spend on those crutches, the less able you are to walk by yourself"

Proffesor Douglas Gentile, Iowa State University

The challenge for dentists

For dentists, the digital revolution offers both opportunities and threats. Dentistry has always been at the forefront of technological innovation, but digital technology is posing a unique set of challenges.

Below are three essential points that I believe all dentists will need to work through if they are to maximise the benefits of the digital revolution while, at the same time, avoiding some of its riskier pitfalls.

1 Digitise your routine

The digital revolution is making routine processes and systems rapidly extinct. Take for example, booking an appointment with a dentist. When you can book an air ticket to New York without once having to speak to another human being; or when you can purchase a car online, again, without even having to encounter a salesperson, the idea of expecting a patient to have to telephone a receptionist to book an appointment with a dentist is unacceptable. To make the most of the digital revolution, audit all your processes and systems and see which of them, from a patient's point of view, might profitably be migrated online.

2 Emphasise the one-to-one

There is a paradox of digitisation that as a dental practitioner, you need to understand. As growing numbers of products and services migrate online, the demand for high-specification human interaction grows ever stronger. This is particularly the case amongst young people, who, according to research, attach additional value to face-to-face interactions. High-end retailers such as Apple know this instinctively – it's why they invest so much time and resources in their customer services. Dental practices are not exempt from this and many have scope for investing more in their 1:1 services. Remember: from a patient's perspective, the fact that dentists are qualified and skilled practitioners is a given. What sets leaders apart from followers is customer service.

3 Social media: time to take control

From YouTube information-clips to advertising via Facebook, social media offers huge opportunities for dentists, particularly in terms of communicating with younger generations. But social media comes with its own health warnings – particularly for a highly regulated profession such as dentistry. If you are interested in engaging with new forms of social media, make sure that you develop a strategy with clear objectives about what you want to achieve. Even more important, appoint a social media manager to oversee online conversations.

Conclusion

The impact of the digital revolution on the dental profession is already having profound consequences, from how dentists train, to how they communicate with patients. In some ways the profession is at a tipping point. As this article has illustrated, the acceleration of digital technology – particularly over the past decade – has been so rapid that we are still coming to terms with the implications. Experts claim that there now exists the technological capability to integrate every aspect of the patient's journey – from booking an appointment to receiving personalised communications from laboratories. Nothing is likely to replace the personal interaction between a dentist and patient – not for now, anyway – but the possibilities digital communications have for enhancing this relationship, are only just beginning.

Dr Paul Redmond
Paul is an expert on generational sociology and the changing world of work

The empowered consumer

A consideration of the clinician-patient dynamic

Kevin J Lewis

When undergoing a surgical procedure, would you prefer to feel like a customer and a consumer as the general anaesthetic starts to take effect, or like a patient?

The World Medical Association's *International Code of Medical Ethics* was formally adopted in 1949. This timing is significant because the Second World War was, in one sense, a trigger for a rebalancing of the relationship between the medical profession and patients where treatment decisions were concerned. During those hostilities, medical officers took many life-changing and even life-ending decisions, with scant reference to the patient. It may be worth making the point, in passing, that when all "patients" are in uniform, their individuality is somewhat eclipsed.

When time is at a premium, and a patient is badly injured and perhaps severely traumatised anyway, there is an arguable case for acting in what is perceived to be the patient's best interests. One of the counter-arguments is that one cannot possibly make that judgement in a holistic way if you don't know anything about the patient. "Doctor knows best" had run its course – or had it?

Medical paternalism was rooted in an age where the workings of the human body were something of a mystery for most of society. As in many highly specialised and/or technical fields, there is a wide disparity between the level of knowledge and understanding of the "expert" and that of the average member of the public. In the intervening years, two factors have been tugging at that disparity in opposing directions.

On one side, healthcare has become extraordinarily complicated and sophisticated with techniques and possibilities undreamt of a generation ago. Many of them are even more difficult for a lay person to understand, with the potential for that gulf in knowledge and understanding to widen.

But on the other hand, knowledge about medicine and health matters generally is no longer the sole preserve of the medical (and dental) profession. The internet changed all that, and knowledge no longer resides only in libraries and academic institutions. It resides at the touch of a finger on a variety of tablet devices to which increasing numbers of patients have access and all of this has a part to play in closing the gap in understanding.

The closure of that gap paves the way for the modern concept of shared decision making, in which the patient becomes an active and central partner in decisions regarding their health and any proposed treatment in connection with it. Even this does not go far enough for some, who argue that the concept of "shared decision making" is the profession's last-ditch attempt to preserve some control over events rather than handing over the reins of power wholly to the patient. Patient autonomy is the new mantra of healthcare, demonstrating a respect for self-determination and the rights and freedoms of an individual to make decisions in relation to what happens to their body.

The law

The law in many countries has shown an eagerness to uphold this principle, even in cases where to do so made it necessary to step somewhat clumsily across other well-established legal principles. The UK medical case of Chester v Afshar (2004)[1] is a particularly good example of this, not least because it hinted at a much wider – and more significant – shift in the balance of power.

This landmark case in UK medical law involved a neurosurgeon (Mr Afshar) who had, by common agreement, carried out a procedure perfectly competently but, unfortunately, there ensued a well-recognised complication of which the patient had certainly been warned. The case hinged on whether Mr Afshar had been a little too reassuring in the way he described the risks and perhaps too dismissive of their scale and significance which led the patient to proceed with the treatment that, in turn, led to her injury. The case was, therefore, all about the quality and validity of the consent obtained from the patient.

Finally, Lord Bingham handed down a dissenting (minority) decision supporting Mr Afshar, on the basis that:

"**The injury would have been just as likely to occur whenever the surgery was carried out, and whoever performed it**". The presiding Judge, Lord Steyn, adopted a very different view, concluding that Miss Chester's "**right of autonomy and dignity can and ought to be vindicated by a narrow and modest departure from traditional causation principles**".

[1] Chester v Afshar UKHL 41, (2004) 4 All ER 587

The panel below provides the third and most revealing judicial perspective of this case.

"**It is plain that the "but for" test is not in itself a sufficient test of causation. A solution to this problem which is in Miss Chester's favour cannot be based on conventional causation principles. The issue of causation cannot be separated from issues about public policy. The law has as its heart the right of the patient to make an informed choice as to whether and if so, when and from whom to be operated on. For many the choice would be a difficult one, needing time to think, take advice and weigh up the alternatives**".
Lord Hope (House of Lords) in Chester v Afshar

The text above illustrates the willingness of the judiciary to set aside the established legal principles of causation, in order to find in favour of a consumer (patient) who had been harmed by a medical intervention.

The internet age

The internet has not only changed the landscape in the obvious way, having given more people access to more information, more conveniently than ever before. It gives the patient access to information and opinions from people they have never met, and are never likely to meet. Not only might this source of information not know best – at least, not what is best for this particular patient – it might not be a doctor either.

Internet-based healthcare information is a world apart (literally, in many cases) from a one-to-one conversation with the healthcare professional who is likely to be carrying out the treatment and who may even have known the patient for an extended period of time.

The concept that patients are "simply consumers of healthcare" who need information and choice can sound very appealing. But the validity of that choice is largely determined by the quality, balance and relevance of the information. If you aren't in possession of all the material facts – or if they are presented to you in an unbalanced or manipulative way – you don't really have a genuine free choice at all. So much for the empowered consumer.

The Mental Capacity Act (2005) in the UK specifically protects (at Principle 3 of the Act) the right of a patient to make unwise or apparently irrational decisions.

Unwise decisions

People have the right to make decisions that others might regard as unwise or eccentric. You cannot treat someone as lacking capacity for this reason. Everyone has their own values, beliefs and preferences which may not be the same as those of other people.

Having their say

The internet has also given patients a voice, just as it has given a voice to people who visit hotels and restaurants, who use a range of other services, or who are willing to share their experiences of a wide range of products, goods and services.

The ability for the users of healthcare services to record their perceptions and post feedback in real time has been embraced by many healthcare agencies as a useful tool in the quest to make healthcare more, transparently, patient-centred and even as a proxy indicator for quality assurance. But the prospect tends to unnerve and alarm many health professionals who fear that only the most dissatisfied patients will take this opportunity.

They might be surprised to discover that the reality tends to be very different, with positive feedback greatly outweighing any negative comments (typically by a factor of 2:1).

What's in a word?

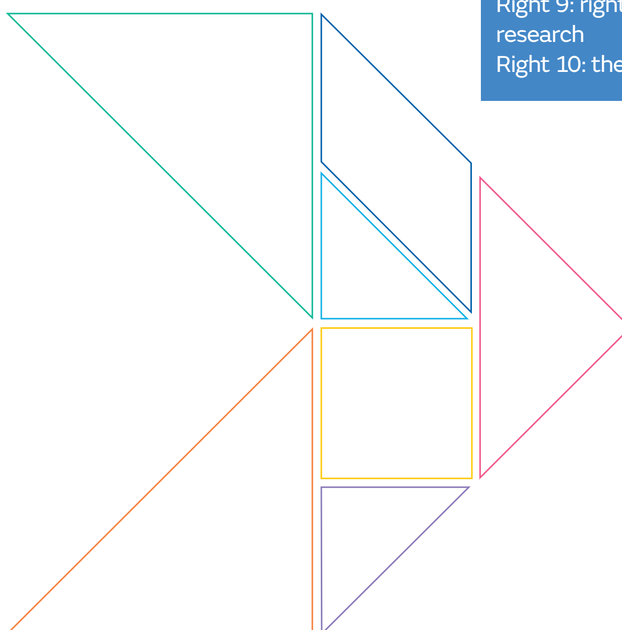
There are some misconceptions surrounding the increasingly prevalent view that patients are simply consumers of healthcare, behaving just as they do when acting as consumers outside the healthcare environment. Many clinicians actively resent the exchanging of the time-honoured term "patient" for the apparently fashionable terms "client", "customer" or "consumer". Not, as some have suggested, because these clinicians still believe doctors should decide and patients acquiesce – and are, therefore, clinging to the remnants of "doctor knows best"– but because they treasure the special relationship of trust between clinician and patient. They also recognise they have ethical obligations to a "patient" that go far beyond the requirements of the average "consumer" transaction in the high street.

It is interesting that you won't hear patients saying *"there were four other consumers in the doctor's waiting room when I arrived for my appointment"*; is it too much to hope that patients themselves place a value on the special relationship that exists when you entrust your bodily wellbeing to a third party simply because they are a healthcare professional? If when undergoing a surgical procedure, would you prefer to feel like a customer and consumer as the general anaesthetic starts to take effect, or like a patient?

Legislative change

Another important source of consumer empowerment is regulatory and legislative change. Dental Protection sees, at first hand, that wide differences exist in the degree of consumerism across all the countries where we have members.

Many governments have discovered there is a favourable electoral dividend to be gained by legislating for increased consumer rights and protections, while shifting the cost burden to the businesses with whom those consumers will be interacting. This is most strongly in evidence in highly developed countries and mature economies. In less developed and less affluent populations, many members of the public don't feel very much like consumers at all.



Some countries have travelled further down this road than others. In New Zealand, for example, the Health and Disability Commissioner Act was passed more than 20 years ago (in October 1994). This was followed by the HDC Code of Health and Disability Services Consumers' Rights Regulations which, from July 1996, established the Code of Health and Disability Services Consumers' Rights.

As was always intended, this Code has since been reviewed at five-yearly intervals and, most recently, in 2014. It remains essentially the same but for a slight strengthening of Right 7 in relation to consent. The Code grants a number of rights to all consumers of health and disability services in New Zealand and places corresponding obligations on providers of those services, including dentists and other dental health professionals

The New Zealand Health and Disability Commissioner

Summary of the Code of Health and Disability Services Consumers' Rights

Right 1: the right to be treated with respect
Right 2: the right to freedom from discrimination, coercion, harassment, and exploitation
Right 3: the right to dignity and independence
Right 4: the right to services of an appropriate standard
Right 5: the right to effective communication
Right 6: the right to be fully informed
Right 7: the right to make an informed choice and give informed consent
Right 8: the right to support
Right 9: rights in respect of teaching or research
Right 10: the right to complain.

If this 20-year-old perspective of the patient as a consumer is now well established in New Zealand, the situation is quite different in South Africa where the environment has been changed quite recently, with a new Consumer Protection Act and amendments to the National Health Act.

There can now be little doubt that patients are seen as consumers in the eyes of the law and, as in other countries, this will impact on both patients and healthcare providers and prompt questions about the doctor-patient relationship. The legislative changes will certainly carry implications for South Africa's two distinct healthcare systems for the private and public sectors respectively.

Professional regulation in healthcare

Five years have passed since the Australian Government passed legislation (summarised as "The National Law") that replaced the previous system of State-by-State registration of health professionals, and introduced a unified system of registration at a federal (national) level and a new body – the Australian Health Practitioner Regulation Agency (AHPRA) – to oversee it.

At the same time, national Registration Standards were created for all 14 health professions, each of which had a National Board that established sets of Guidelines and Policies. An extract from one example of this framework is illustrated in the panel to the right, this being part of the new Code of Conduct for registered health practitioners of all kinds.

One does not have to look too far to see the influence of consumerism and formal recognition of the need to reflect consumer expectations in the regulatory requirements for health professionals in Australia.

If you are not in possession of all the material facts, you really don't have a genuine free choice.

From Code of Conduct for registered health practitioners. Dental Board of Australia - March 2014

Made under section 39 of the Health Practitioner Regulation National Law Act 2010 ("National Law")

3.3 Effective Communication
An important part of the practitioner-patient/client relationship is effective communication. This involves:

a listening to patients or clients, asking for and respecting their views about their health and responding to their concerns and preferences

b encouraging patients or clients to tell a practitioner about their condition and how they are managing it, including any alternative or complementary therapies they are using

c informing patients or clients of the nature of and need for all aspects of their clinical care, including examination and investigations, and giving them adequate opportunity to question or refuse intervention and treatment

d discussing with patients or clients their condition and the available health care options, including their nature, purpose, possible positive and adverse consequences, limitations and reasonable alternatives whenever they exist

e endeavouring to confirm that a patient or client understands what a practitioner has said

f ensuring that patients or clients are informed of the material risks associated with any part of a proposed management plan

g responding to questions from patients or clients and keeping them informed about their clinical progress

h becoming familiar with, and using wherever necessary, qualified language interpreters or cultural interpreters to help meet the communication needs of patients or clients, including those who require assistance because of their English skills, or because they are speech or hearing impaired (wherever possible, practitioners should use trained translators and interpreters rather than family members or other staff; information about government-funded interpreter services is available on the Australian Government Department of Immigration and Citizenship website).

Jamaica's legislative change in the early 1990s is another interesting example that illustrates the recurring themes in the international development of consumerism generally – and how healthcare becomes drawn into those wider changes. This established the Consumer Affairs Commission (formerly the Prices Commission) and, unlike the examples quoted above from South Africa, New Zealand and Australia that illustrate healthcare reforms that absorb and reflect elements of wider consumer rights, the extract in the panel on page 16 establishes those wider consumer rights from which healthcare provision is not exempt. In short, healthcare is not treated as a special case.

That has also been the approach in many other countries, especially in Europe, where all member states are required to introduce legislation to comply with European Directives. One such Directive resulted in significant reforms in the area of Consumer Protection in 2008 and again, the ensuing Regulations applied to healthcare every bit as much as any other business activity.

Consumer Affairs Commission of Jamaica

Consumer rights
There are certain basic and inalienable rights to which every consumer in Jamaica is entitled. But unless you know what these rights are, you could be cheated out of them.

Basic needs
The right to basic goods and services that guarantee survival: adequate food, clothing, shelter, health care, education and sanitation.

The right to safety
You have a right to safety and, therefore, the right to be protected against those goods and services that may be hazardous to your life and health. The right to safety has been broadened to include the concern for consumers' long-term interests, not only their immediate desires.

The right to be informed
You have the right to be given the facts that you may need to make informed choices or decisions. The right to be informed goes beyond avoiding deception and the protection against misleading advertising, labelling or other practices.

The right to choose
You have the right to have access to a variety of products and services at competitive prices and, in the case of monopolies, to have an assurance of satisfactory quality and service at a fair price.

The right to be heard
You have a right to be represented so that consumers' interests receive full and sympathetic consideration in the formulation and execution of economic policy.

The right to fair settlement of just claims
You have the right to a fair settlement of just claims. This right has been generally accepted since the early 1970s. It involves the right to receive compensation for misrepresentation or shoddy goods or services and where needed, free legal aid or an accepted form of redress for small claims should be available.

The right to consumer education
You have the right to acquire the knowledge and skills to be an informed consumer. The right to consumer education incorporates the right to the knowledge and skills needed for taking action to influence factors that affect consumer decisions.

The right to a healthy environment
You have the right to a physical environment that will enhance the quality of life. This right involves protection against environmental problems over which the individual has no control. It acknowledges the need to protect and improve the environment for present and future generations.

Summary

In many parts of the world, there has been a shift in the clinician-patient relationship, from a traditional paternalistic model to a much more consumerist model.

The danger is that the more healthcare becomes a consumer "commodity", the more the behaviours of both patients and healthcare providers will shift to become those seen in the marketplace rather than a special relationship in which professional ethics are mutually recognised and highly valued by both parties. Interestingly enough, this has been recognised in the highly commercial environment of Hong Kong. The Code of Practice published in Hong Kong, includes the following statement:

The Dental Council of Hong Kong
Persons seeking service for themselves or their families can be vulnerable to persuasive influence, and patients are entitled to protection from misleading advertisements. Promotion of dentists' services as if the provision of dental care were no more than a commercial activity is likely both to undermine public trust in the dental profession and, over time, to diminish the standard of dental care.

This insightful approach is refreshing to discover. The solution, then, is not to try to hold back the tide – as this article has demonstrated, it is too late for that – but to find a middle ground in which healthcare professionals understand and respect patient autonomy.

The Hippocratic ethical principles of beneficence (act in the patient's best interests) and non-maleficence (above all, do no harm) need to be rediscovered and reapplied in the modern world of consumerism. But, in that new world, the clinician should be an informed and benevolent helper in the patient's own decision making, not the usurper of the patient's right of autonomy.

Many of the very same people we call patients are, unquestionably, consumers the very moment they step outside the confines of a dental practice. It is a dilemma that serves as a metaphor for change itself. The challenge is to preserve the best of what we have learned from history while being willing to incorporate the needs of the present and the likely shape of the future.

Kevin J Lewis
The Dental Director
of Dental Protection

Complexity in clinical practice

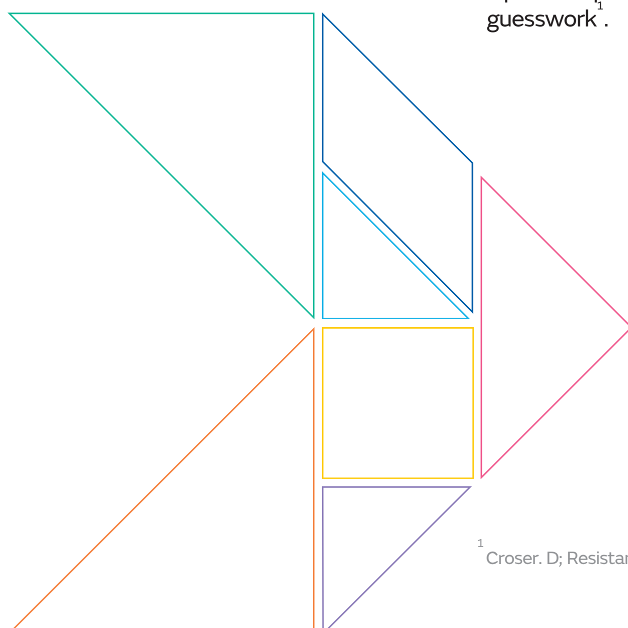
Clinical practice is at its most complex when it comes to decision making. The process is composed of a host of psychological and behavioural variables that co-exist in a complex adaptive system we call the human body.

Multiple unforeseen circumstances can sometimes converge to work against even the best clinicians

Raj Rattan MBE

For the dental team, complexity in clinical practice arises from:

1 Diagnostic uncertainty
2 Multiple treatment options
3 Patient preferences and choice
4 Lack of high level evidence to support the intervention
5 Competency of the clinician
6 Communication and consent
7 Perception – values and belief systems – cultural and experiential



1 Diagnosis

Uncertainty in the diagnostic process may result in a misdiagnosis. That is, a diagnosis that is overlooked, wrong or delayed until some subsequent definitive test or other new finding detects it.

Misdiagnosis can result from:

- Ambiguity of clinical data
- Variations in its interpretation
- Uncertainty about relations between clinical information and presence of disease
- Inconsistent results from special tests
- Unusual symptoms.

The root causes are:

- Errors related to special tests
- Cognitive errors related to over confidence or complacency
- Lack of time
- Failing to listen to the patient's reported symptoms.

The failure to record the diagnosis is a common omission in clinical records and compromises any defence where there is a threat of litigation. Dental Protection has noticed this problem arising most frequently when the patient has attended in an emergency. Without a correct diagnosis, the use of antibiotics to treat a patient's painful condition verges on guesswork[1].

2 Treatment options

Clinical decisions should be influenced by exploring and respecting "what matters most" to our patients as individuals, and should only be presented when a diagnosis has been made, discussed and noted in the clinical record.

Writing in the Journal of the American Dental Association in 2004, Amid Ismail and James Bader noted[2]: "In developing appropriate treatment plans, dentists should combine the patient's treatment needs and preferences with the best available scientific evidence, in conjunction with the dentist's clinical expertise. To keep pace with other health professions in building a strong evidence-based foundation, dentistry will require significant investments in clinical research and education to evaluate the best currently available evidence in dentistry and to identify new information needed to help dentists provide optimal care to patients."

Treatment planning is reliant on:

- Pattern recognition through experience
- Critical thinking and understanding causal relationships
- Effective communication
- Adopting an evidence-based approach
- Critical reflection.

3 Patient preference and choice

The historical bias in the dentist/patient relationship has been paternalistic and clinical interventions were largely determined by the practitioner on a cause-and-effect basis in a culture of "dentist knows best". This reductionist approach has no place in today's world of patient-centred care, choice and shared decision making. In short, autonomous patients are: "Choosers who act intentionally, with understanding, and without controlling influences that determine their actions[3]."

[1] Croser. D; Resistance rules; *Riskwise UK 46 2015*

[2] Ismail. A & Bader. j. Evidence-based dentistry in clinical practice *JADA* 2004 Volume 135 (1), 78–83)

[3] Stigglebout, *J Med Ethics* 2004;30:268-274 doi: 10.1136/jme.2003.003095

Standing[4] described clinical decision making as the application of "clinical judgement to select the best possible evidence-based options to control risks and address patient's needs in high-quality care for which you are accountable".

This statement emphasises:

- The use of professional judgement
- The use of current information sources (evidence)
- That choices are made about what, who, where and when and why things are done (options), evaluating the choices that are made (selection)
- Accountability for those decisions.

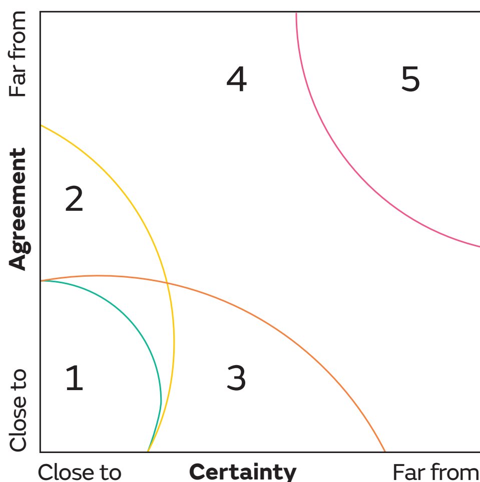
The three-step model shown in figure 2 is a useful, practical summary of the process and derived from "Shared Decision Making: a Model for Clinical Practice[5]."

[4] Evidence-based care

To ensure patients receive high quality care, clinicians should ask:

- Are we doing things in the right way?
- What is the evidence relating to our prescribing preferences?
- Is the clinical care and treatment we are providing effective?

Figure 1
Risk zones in clinical decision making



1 Controlled undisputed
2 Political
3 Judgemental
4 Zone of complexity
5 Disorder

Some planned interventions may carry greater risk than others, depending on the evidence base available to support them. Where there is doubt in a claim for clinical negligence, experts may be called upon to provide an opinion. Lack of agreement is more likely to drive a claim forward. Some interventions carry more risk and clinicians should be aware of the heightened risks associated with elective and more invasive procedures.

Ralph Stacey is professor of management at the University of Hertfordshire. His matrix relates the two dimensions of certainty of outcome and extent of agreement. This can be adapted to the clinical setting where the certainty of a clinical outcome is related to agreement amongst clinicians for a particular intervention. The matrix (figure 1) helps to identify risk zones graded from green (safe) to yellow (small risk) to orange (medium risk) and red (high risk).

Zone 1 – Clinical decision making is safe and outcomes are predictable and low risk. This is the comfort zone where the intervention is well supported by evidence and there would be universal agreement amongst professionals about its appropriateness. If challenged, there would be professional consensus because clinical protocols will exist.
Zone 2 – Introduces political bias where there may be disagreement amongst institutions and policymakers, as well as differences in opinion between different stakeholders.
Zone 3 – Clinicians exercise their judgement based on experiential learning. This zone introduces complexity where treatment options and outcomes are not as predictable and where there may be scope for differences in clinical opinion and outcomes.
Zone 4 – Occupies the greatest space in the matrix and poses the greatest challenge because there may be differences of opinion amongst professionals but also where there may be system constraints or bias which may direct a clinician away from the safer zone. The optimum intervention may not be achievable because of financial constraints which may be at system level or at patient level. This context creates challenges for the clinician and adds another layer of complexity.
Zone 5 – Presents the greatest hazard. Any treatment in this zone that comes under scrutiny is highly likely to be the subject of complaints, litigation or regulatory action.

Figure 2
Dr Standing's 3-step model[4]

Step 1
Choice talk

- reasonable options explained
- justify choice
- check patient reaction

Step 2
Optional talk

- more detailed information of the options
- risks and benefits
- check knowledge
- summarise

Step 3
Decision talk

- supporting the patient in considering the options
- elicit preferences
- make a decision
- offer review

[4] Dr Mooi Standing: Clinical judgement and decision-making in nursing – nine modes of *Clinical Judgement and Decision Making for Nursing Students*; Sage Publications Ltd. London. (2011)

[5] Elwyn, Frosch and Thomson: Shared Decision Making: A Model for Clinical Practice: *J Gen Intern Med.* 2012(10): 1361–1367

5 Competency of the clinician

Clinicians must maintain their knowledge and skill at a level necessary to perform clinical procedures safely and in a way that optimises the clinical outcome. The requirement do so, is stated in ethical guidance throughout the world and underpins the delivery of quality dental care.

It is the goal of assessment at undergraduate level to ensure that reliable measurements of a student's performance are used to ensure clinical competence.

Whilst this in itself cannot guarantee performance in the real world, it has a high predictive value. Beyond undergraduate training, the responsibility to upskill and maintain contemporary standards rests with the individual clinician.

Dental Protection encourages dental members to participate in well-designed, relevant educational programmes to achieve this and to maintain their skills and increase their competency as part of a wider risk management strategy.

6 Communication and consent

A dentist who continues to adopt a paternalistic point of view risks complaints, possible litigation and an investigation by his/her national regulator or registration body. The relationship between the clinician and the patient is founded on the principle of "mutuality".

Many legal challenges arise because certain treatment outcomes did not meet the patient's expectations or the patient has not been adequately informed about the treatment and valid consent has not been obtained. In addition, many patients report that they were not involved in the decision-making process or felt they were misled or misinformed about the treatment they received. The data highlight the complexities of clinical decision making and the importance of co-diagnosis and managing the overall patient experience.

The dentist/patient relationship is built on trust. In terms of the business economy, dentistry is described as a credence purchase. In his paper, *Credence Goods and Fraudulent Experts*[6], Winand Emons discusses the "information asymmetry" that exists between buyer and seller where the seller is an expert in the field and the buyer knows very little. This is a situation that "creates strong incentives for opportunistic seller behaviour".

The opportunity for bias can also impact on the consent process where the risks of a particular intervention may be understated or overstated to the seller's advantage and poses substantial risks from a medico-legal perspective.

This economic lens may appear to be an artificial construct, but it is worth noting that much of the empirical evidence in economic literature that relates to credence goods is based on the markets for car repairs and healthcare services, with studies to support the association.

Dentists must believe in the principle of self-determination and be able to communicate effectively and overcome the challenges in situations where the patient:

- Did not want to be involved in the decision
- Lacked capacity to make an informed decision
- Is confronted by information that is difficult to communicate
- May have low literacy in dental matters.

For more information on consent, see Dental Protection's dental advice booklets on consent in the risk management section of the website.

7 Perception

Studies show that shared decision making has a positive effect on purchaser satisfaction and the perceived quality of outcomes. A scrutiny of files in the Dental Protection archive – relating to claims and complaints – confirms Robert Bunting's[7] observation that the existence of so-called predisposing factors such as rudeness, poor inter-personal relationships, poor communication and inattentiveness will often motivate patients to sue or complain when precipitating events that cause harm or injury manifest during clinical procedures. These pre-disposing factors impact on the patient's perception of the clinician and his/her competence.

Perception of quality is also influenced by the environment. A professional, clean and uncluttered environment presents a different image to one that appears dated and disorganised. Code of dress, professional attitudes and effective communication all contribute to the patient's perception because they help to create all-important positive first impressions.

Conclusion

Here we have started the process of categorising the challenges, risks, judgements, interventions and perceptions that impact on the work of dentists and dental teams. An understanding of the complexities of clinical decision making is an integral part of risk management in the modern era.

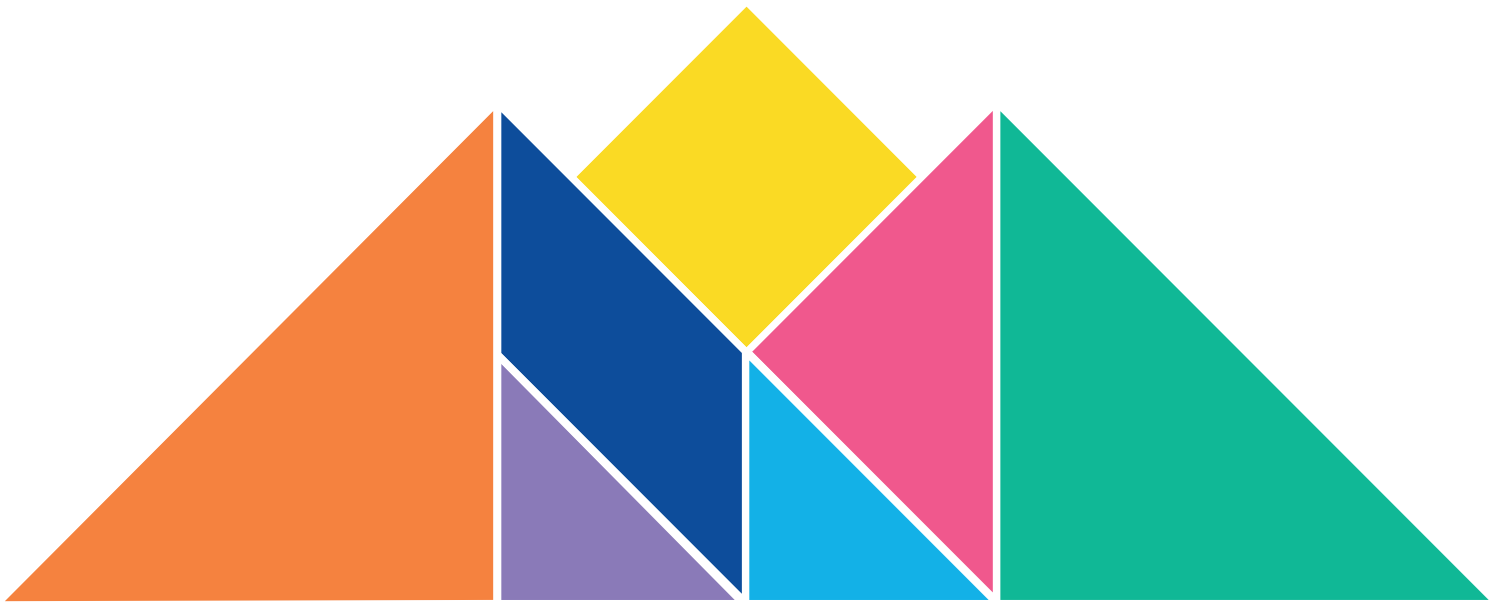
Raj Rattan MBE
Raj is a general dental practitioner who has been involved in the training of young dentists for many years. He is an author and international lecturer. Raj is also a Senior Dento-Legal Consultant for Dental Protection

[6] Emons.W: Credence Goods and Fraudulent Experts *The RAND Journal of Economics*: 1997 Vol. 28 (1)

[7] Bunting R F, Benton J, Margan W D: Practical risk management for physicians. *J Health Risk Management* 1998; 18(4): 29–53

Change in the external environment

The shrinking world 21
Socio-economic changes 22
When worlds collide 23
The blame and compensation culture 24



The shrinking world

Taking flight – and its “butterfly effect” on healthcare

Coast to coast, host to host

Long-haul aircraft, and especially “super-jumbo” aircraft with greater passenger capacity, have become much more effective vectors of infectious disease than the humble mosquito ever managed. A pandemic in one country can, within 24 hours, create a risk in the surgeries of another on the other side of the world. Public health messages and public and professional guidance have tended to be reactive – not always keeping up with the speed of unfolding events and not always right first time. Global health can only ever be as good as the weakest link in the chain. In recent years, tuberculosis, avian influenza, SARS and Ebola are examples of the risks.

The world had started to shrink long before the global financial crisis of 2008. Since the 1980s, there had already been a huge increase in international travel. This includes a hike in the number of passengers carried per flight, the average number of miles travelled per flight and, indeed, the average cost of air travel. At first sight, these trends seem to have little to do with healthcare but, in fact, many dentists working in many parts of the world are directly affected – professionally and personally.

Accelerate

One effect of the global financial crisis was to accelerate things already happening for a number of other quite separate reasons. The financial accessibility of flying has whetted the appetite of many of the world’s population who can look over and beyond their immediate horizon. Dentists were already moving in greater numbers to work in other parts of the world because of the professional and personal opportunities. This is especially true of recently graduated or younger dentists who might value the opportunity to do a bit of travelling, funded by a little dentistry, while they are still young and relatively free of other commitments.

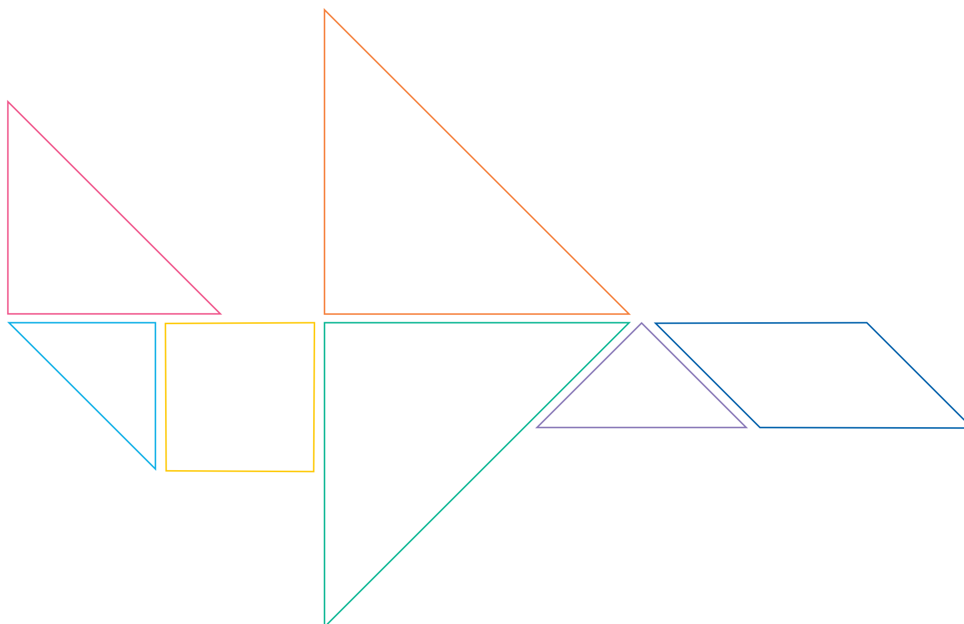
Migration

A more recent phenomenon has been the economic migration of dentists that, at first glance, might seem to be an oxymoron. But the deterioration of many of the world’s economies has been on a scale that draws even professional people into considering options. Workforce issues in some countries have also led the governments of these countries to actively seek recruits from other parts of the world – raising some genuine ethical concerns when relatively well-developed economies are further depleting the already overstretched healthcare workforces of less affluent countries.

A melting pot

In parallel with all this, patients and potential patients are on the move, too, and many dental practices are home to their own diverse population, with dentists, staff members and patients from different ethnic and cultural backgrounds. Where there is no shared language over which all concerned have an equal command, this can lead to communication difficulties, misunderstandings and some heightened clinical risks.

In some countries, the phenomenon of “medical tourism” capitalises on the widely differing costs of healthcare provision and some governments are actively promoting and supporting this as a matter of economic policy. But, while the attractions are self-evident for the patient, healthcare provider and the economy of that chosen country, the reverse is true for the “home” country of the patient concerned. There are significant additional obstacles and practical complications when problems arise with the treatment – and, sometimes, dentists are being confronted by issues that they had no part in creating.



Socio-economic changes

In order to survive, we must learn to adapt. Embracing change inevitability brings opportunities – but it can also mean unwelcome new risks

Business. Profession. Both?
Whether dentistry is a health profession or a business is a long-running debate. Even in times of austerity, personal professional accountability makes it difficult to defend an allegation of negligence or misconduct by citing financial constraints or management policies

Societies allocate scarce resources to meet the needs of their people. In dentistry, levels of disease and social inequality define that societal need. It is also determined by a myriad of personal, financial, technical, legal, political, environmental and cultural levers – all unrelated to health.

During the global economic downturn, the perception and, sometimes, reality of financial pressures on both the providers and recipients of dental services have coincided with a public's growing expectations of safe, affordable, aesthetically pleasing and accessible dentistry. If there is significant disparity, a political solution may be required but Governments round the world have been forced to look more closely than ever at their public expenditure and with the insatiable demands of healthcare, dentistry's voice can be hard to hear.

Affordability

Different countries have felt the effect of the economic upheavals to a differing extent and at different times. While some countries appear to be recovering, others have economies that are struggling or static. This affects the extent to which patients can afford any non-essential dental care, and it forces patients to reassess their household spending priorities, needs and wants.

Patient advocates

An awareness of the economic and demographic factors that are impacting on the oral health of their patients provides an opportunity for you to act as an advocate for those less able to express their needs. National dental associations and colleagues working in public health already have a role in facilitating dental care for those whose needs remain unmet. But that doesn't mean that the individual clinical team can't still make a useful contribution. A number of surgeries offer free screening for dental disease at different periods of the year or make a charitable donation of their time and skills to a rota of colleagues who offer free dental treatment to those in need.

Oral hygiene initiatives

An increasing population of elderly patients in nursing homes or supported by carers in their own homes has identified a new category of need. A population of patients with heavily restored teeth following initial dental treatment in the 1950's and 60's are facing the prospect of a diminishing ability to maintain adequate levels of oral hygiene to protect the dental treatment they have received to date. By training the careers and nursing home owners to provide supervision of basic oral hygiene measures, there is an opportunity to improve the situation for this patient group.

Dentist, therapists and hygienists are perfectly situated to provide that training or to encourage carers to engage with the oral hygiene issue (YouTube has several videos of techniques for plaque control aimed at patients with reduced mobility). The dental team could address the needs of the senior members of the local population in an altruistic manner – but there could also be an opportunity to explore the benefits of providing basic oral hygiene training to staff in care homes for the elderly.

Any dental treatment should ideally be provided in your own dental surgery- but if the patient is not ambulatory they should be referred to a team that is equipped to offer domiciliary treatment, wherever this service exists. (see "An ageing population" page 28).

When worlds collide

The delivery of information continues to rapidly change. Social media is a beguiling global tool but, with this digital "knowledge" and a rise in consumerism, what else may we expect?

More than 40% of consumers say that information found via social media affects the way they deal with their health
(source: Mediabistro)
Why this matters: Health care professionals have an obligation to create educational content to be shared across social media that will help accurately inform consumers about health related issues and out shine misleading information. The opinions of others on social media are often trusted but aren't always accurate sources of insights, especially when it comes to a subject as sensitive as health.

https://getreferralmd.com/2013/09/healthcare-social-media-statistics/

Across the world, the rise of consumerism is the answer regulators and lawyers inevitably give when asked to name the most significant driver of complaints. The patient now acts as an active willing participant in treatment and not as a recipient of care in a "dentist knows best" fashion. The patient is often armed with information from the internet, a very clear idea of what they want, at a price they are willing to pay.

This collision of health, money, consumer choice and patients' best interest has the potential to generate a perfect storm that will produce legal challenges, claims, unrealised expectations and unfulfilled promises – unless the vital ingredient of good communication is the calming influence.

Misunderstanding

Consumerism has certainly arrived but dentists, like some doctors, may resent this intrusion into their busy professional world[1]. Patients may come armed with preconceived ideas of what they want and it takes time to change long-held beliefs or misunderstanding of information. Clinicians may also feel their professionalism is being undermined by having to explain or correct web-sourced information, the provenance of which may be dubious.

With consumerism comes a demand for choice. But, in reality, a patient's ability to choose is constrained by the range of options suited to them and also their ability to assess the quality of what they are choosing. Patients often asses the quality of what they get by what they can feel or see that may have little bearing on the quality of treatment they receive.

If patients act as consumers when making their purchasing decisions, there is a great danger they will easily be persuaded by "bright and shiny" things. Economists and marketeers call these "searchable" characteristics. These are features that are easily identified and then compared for the best price eg: cameras, cars, computers or – in dental terms – veneers, implants and whitening treatments.

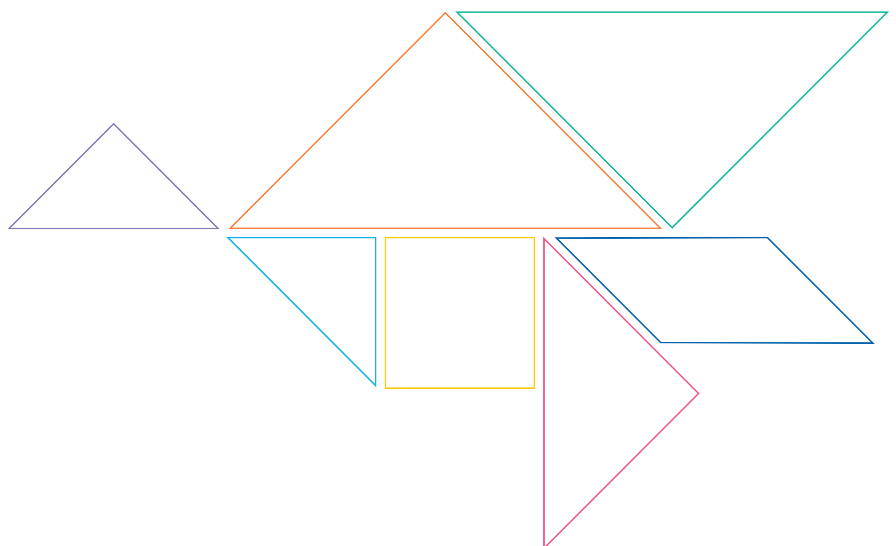
In many countries, websites are starting to appear that invite patients to rate their dental practices on a number of different aspects eg: infection control, friendliness, etc and to add comments on the quality of care they have received and how likely they are to recommend the practice.

In addition to prospective patients, organisations that commission dental services and regulators use these websites to gauge the quality of care and these subjective comments may determine funding or disciplinary action.

The job of dentists is not to reject the consumer manifesto of choice and information. A more positive approach is to become skilled in its ways and to capitalise on them whilst focusing characteristics of dentistry that promote credibility[2].

Such "credence attributes" cannot be determined either before or after purchase or, indeed, consumption of the service. It is only sometime afterwards that the effectiveness of the service can be evaluated – much like medical or legal advice. In dentistry, certain recommendations or care will have an immediate effect – pain-relieving treatment, for example. Here, what builds trust and credibility is not the shiny things that patients have seen, but the intangibles of expertise, knowledge and empathetic care.

These skills, delivered by the whole dental team, will last a lot longer than the rush of consumerism that may have brought the patient to the practice in the first place.



[1] Haug MR, Levin, B. Practitioner or patient – who's in charge? *J Health Soc Behav*. 1981;22(3):212-229

[2] Darby, Michael R., and Edi Karni. 1973. "Free Competition and the Optimal Amount of Fraud." *Journal of Law and Economics* 16(1): 67-88

The blame and compensation culture

High hopes and great expectations may skew the patient's view of treatment outcomes. But unpredictability and human error are a reality, so how best to turn the tide?

The words of a familiar strapline once used by a personal injury law firm – "where there is blame, there's a claim" – encapsulate the fear of a "blame and compensation" culture. They promote the prospect of financial benefits whenever something is perceived to have gone wrong. Such a culture can have two other adverse effects beyond increased litigation:

- Increased regulation as a result of the desire to hold someone responsible
- The potential to encourage organisations and individuals to hide mistakes rather than share them to the benefit of the profession as a whole.

The prevailing tort law legislation in any jurisdiction will influence the frequency of litigation. However, the common factor is the ever-present wish to pursue claims by patients who consider they have been injured as a result of negligent treatment. The expectations of patients have undoubtedly changed due, largely, to the availability of digital media channels that promote new techniques and procedures as and when they become available. With elevated expectations – and a more consumerist approach – it is easy to see how the number of challenges increase if these expectations are not met. The knock-on effect is that more routine matters – such as the loss of vitality or progression of periodontal disease – are now challenged, despite the team's best efforts. In a world where technology is increasingly predictable, patients appear far less likely to accept the unpredictability of human tissue.

Influence

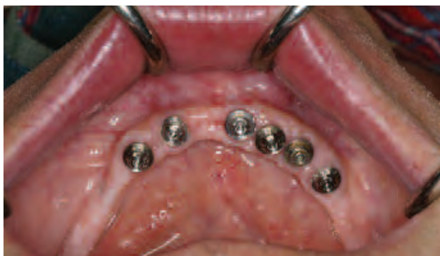
Unfortunately, there will always be human error, leaving the clinician vulnerable to challenge. However, this risk is significantly reduced if the patient was satisfied with any previous experience with that clinician and/or the practice. In other words, irrespective of the extent of a "blame and compensation" culture, colleagues can dramatically influence the level of risk they face by their behaviour, attitude and communication with patients, particularly when there is an adverse outcome.

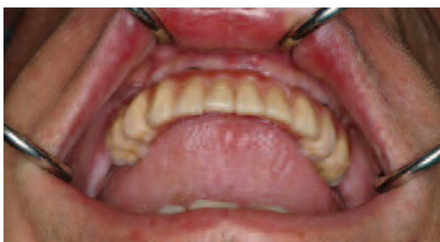
Politicians have a part to play. In New Zealand, the well-established "no-fault" accident compensation scheme (ACC) removes the "blame" element and, with it, much of the adversarial and emotional overtones.

Whilst an increase in claims and regulatory challenges may follow if the compensation culture expands and gains traction, the converse would be true if we can turn the tide by reducing the number of challenges from patients by:

- Meeting their expectations
- Recognising patient autonomy
- Developing strong and trusting professional relationships.

Dentists cannot change the external culture and environment – but they can and should try to protect themselves from it.





Case study
A dentist provided six implants for a patient in order to create support and retention for a prosthesis. Unfortunately, two of the implants subsequently failed and, whilst the dentist offered to repeat the procedure for these two implants, the patient had lost confidence in his ability and asked for a refund.

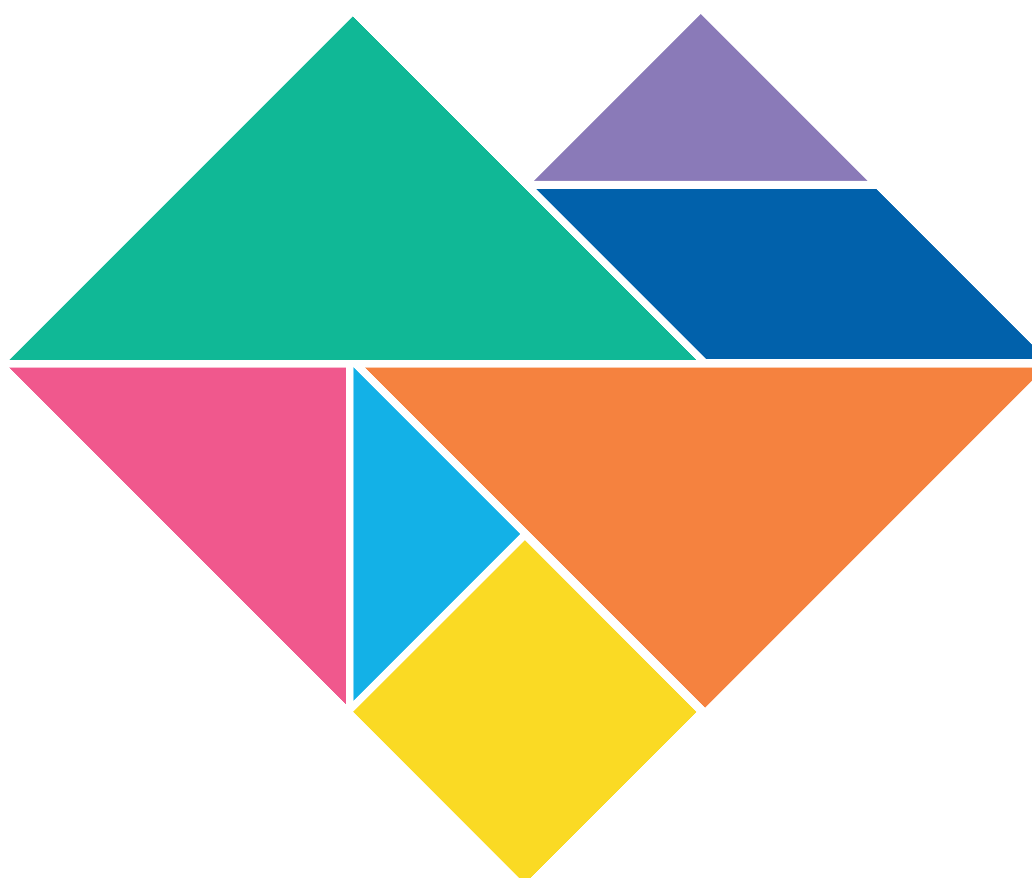
The dentist was happy to return the fees for two of the implants but decided to subtract a figure for the time he spent in surgery. Naturally, the patient felt disadvantaged and, with the dentist standing his ground, the hitherto amicable relationship became acrimonious, leading to a claim and a challenge from the national regulator.

Whilst it could be difficult to persuade a patient to accept that not all dentistry is predictable, it is even more difficult to achieve an amicable resolution when a patient considers they have been disadvantaged through no fault of their own.

Even though patient expectations may change, the clinician needs to ensure that they can view those new situations from the patient's perspective as well as their own.

Changes within healthcare

Advances in Science and technology 26–27
An ageing population 28
Changes in culture 29
Evidence-based practice 30
Changing attitudes to healthcare professionals 31–33

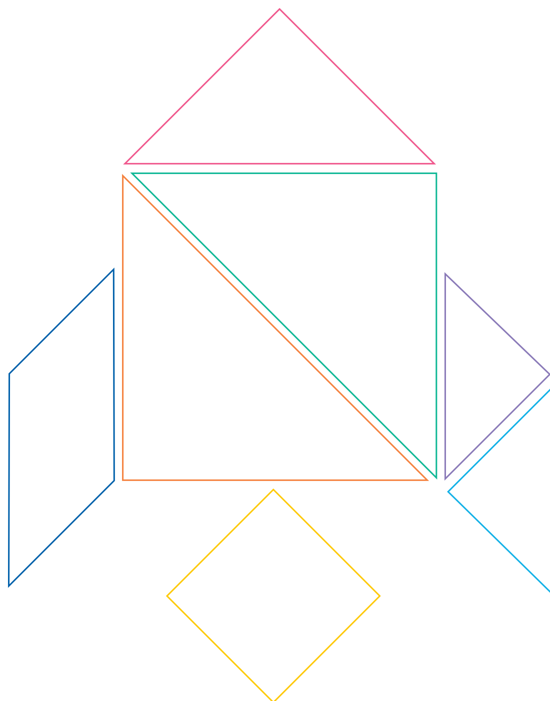


Advances in science and technology

A fast-moving world calls for a rapid response – or does it? Clinical competence matters more than exciting engagement

New dawn dentistry
- Gene therapy
- Nanotechnology
- Bioinformatics
- Teledentistry.

Rapid scientific and technical advances challenge and stimulate us in our personal and professional lives. As dentists and dental care professionals, we need to look at these advances and decide whether we can – or want to – incorporate them into everyday practice.



These advances:
- Affect the management of patients
- Impact on diagnostics, treatment planning and communication
- Present new strategies for treating nervous patients
- Create developments in equipment, dental materials and techniques
- Alter the treatment available to patients
- Lead to the evolution of consumer dental products

We need to ensure any changes we adopt are within our competence and we are confident about patient safety. Advances may be exciting and grab our interest, but can they realistically be used in a practical, cost-effective way that can benefit our patients safely?

Gene therapy

Gene therapy is an ongoing approach to treat, cure and ultimately prevent disease by the use of genes. We read about developments into the “growth” of teeth and other dental tissues and the ways scientists can genetically alter disease pathogens to help eradicate caries and periodontitis. How near are we to replacing traditional restorative therapy with regenerative therapies? How close is research to stimulating enamel and dentine formation with growth factor therapy? Are we on the brink of replacing conventional root canal treatment with stem cell regeneration of pulp tissue? And, what about using bio-engineered teeth for implantation?

Nanotechnology

Nanotechnology is research and technology development at the atomic, molecular or macromolecular level. Composite resins for restorations and artificial teeth that contain nano-sized filler particles; are easy to shape, and have a high degree of aesthetics, strength and resistance are already on the market. Other nanomaterials have been used for the delivery of tetracycline into periodontal pockets and triclosan and calcium carbonate in toothpastes.

Bioinformatics

Dental bioinformatics has been defined as the “application of computer and informational sciences to improve dental practice, research, education and professional management”. In clinical practice, it is used for information sharing, communicating with patients and prospective patients and for auditing and assessing treatment efficacy, patient and practice outcomes. Computer-aided design and computer-aided milling (CAD/CAM) processes are being used for restorations such as Procera all-ceramic crowns. Computer software, such as Clincheck, enables professional collaboration for making decisions in complex orthodontic treatment planning, such as that used in the Invisalign orthodontic system.

Teledentistry

Digital technology has been used for the remote provision of dental care, advice or treatment using information technology and telecommunications rather than direct personal contact with the patient. A dentist in one country may collaborate with a colleague in another in the provision of care for a patient. However, in this virtual world there are complications and risks. Is the patient aware of the credentials of the remote practitioner or collaborator? Who has the responsibility for medical history, examination, treatment decisions, data collection and patient confidentiality and consent? What and where and to whom can the patient bring legal action? Are you practising illegally if you are participating - albeit remotely- in the treatment of a patient in another country where you are not registered? Dental Protection has already assisted members with cases of this nature.

The practitioner's role

A major hazard of getting involved with cutting-edge technology and techniques so quickly is the challenges posed when sharing potential risks and benefits with the patient. Gaining valid consent may prove a problem, too, if the patient struggles to understand what is being proposed. This leaves the dental professional vulnerable to complaints and litigation.

The use or recommendation of a new technique needs to have a strong foundation and, if it is experimental in nature, the patient has a right to know this. Operational risk management controls means that clinicians should consider the use of new equipment, new instruments and new materials in the treatment of a patient if one can do so safely and to an appropriate standard of training, skill and competence. By being at the forefront of change there is also the difficulty of finding truly independent, authoritative experts to provide credible expert witness evidence. This is necessary to support what you were doing in the event that something goes wrong. We owe it to our patients to maximise the benefits and minimise the risks of new technology and scientific advances in dentistry. In doing so, we will be protecting ourselves against the threat of complaints and litigation and other forms of professional challenge.

Minamata Convention on mercury

It is unusual for dental practice to be affected by global agreements. The 2013 Minamata Convention[1] describes the international community's commitment (128 signatory countries at time of writing) to combat the global threat to human health and the environment from mercury pollution worldwide.

The phasing down of dental amalgam use is at different stages in different countries. It coincides with the public's aspirations for white fillings, but also poses some clinical and ethical questions for dentists advising their patients about restorative materials (see Biomaterials, page 42).

Case study

At her examination appointment, the patient said that she had heard that "amalgam fillings were banned now because they were poisonous". She wanted all her silver fillings removing immediately but was worried about the cost.

Having asked about her general health – and carried out a full examination – the dentist told the patient about the safety of dental materials and about the reasons for the move away from dental amalgam usage. She explained that the scientific evidence indicated that was no need to remove her existing sound fillings[2] and that a range of materials was available to restore the cavity she had noted.

She described the risks and benefits of each material for this particular situation, together with the costs of the options before giving her a written estimate of the charges.

The patient left feeling reassured she now had enough knowledge about the proposed treatment to make a valid choice.

In this case, the balanced explanation of the facts to the patient was facilitated by removing the emotional triggers from the conversation.

[1] http://www.mercuryconvention.org/

[2] http://ec.europa.eu/health/scientific_committees/emerging/docs/scenihr_o_046.pdf

An ageing population

If current life-expectancy trends continue, we can all expect to live longer and healthier lives. So, where does that leave the dental team?

As life expectancy increases, the population demographic has altered in many countries around the world. The nature of dentistry is also changing, because patients are now retaining their teeth throughout an extended lifespan.

Whilst younger members of the population demonstrate reduced levels of caries, the older population has large numbers of heavily restored teeth. With insufficient room for their perfect teeth because none have been lost through disease, many of the young may need additional orthodontic treatment. At the other end of the scale, there are indications that the complex dental needs of the elderly are sometimes neglected.

Advances in medicine play a major role in prolonging lifespan. As a consequence there is an ever-increasing complexity of medication being given to older patients to manage their diseases. Sadly, those same drugs impact on both systemic and oral health.

Appropriate public health planning for this changing focus in demand is vital if the altered needs of the population are to be adequately met.

Dry mouth

There is a long list of xerogenic drugs; any one or a combination of them may render a patient – previously dentally stable – susceptible to new primary disease, particularly if the apparent "newly dry mouth" is relieved with sugared drinks or snacks.

Recession

As the cohort of elderly patients grows, gingival recession is likely to be ever more frequently seen and recorded. The exposed root dentine and cement-enamel junction is often irregular, less mineralised and more complex in shape to clean. This can lead to caries in areas of the tooth that are relatively difficult to access and vulnerable to disease progression. Coupled with xerostomia and reduced dexterity, excessive exposure to sugars can lead to aggressive progression of caries.

A robust regimen of dietary advice, saliva substitutes, appropriate fluoride therapy and oral hygiene instruction may make the difference between maintaining a healthy natural dentition or tooth loss[1].

Tooth wear

Non-carious tooth surface loss (tooth wear) is an inevitable consequence of ageing. It should only be considered pathological if it is a threat to the survival of a tooth or if it is a concern to the patient. Adhesive dentistry has revolutionised the treatment of most types of dental pathology but it is, perhaps, in the management of tooth wear in which the non-destructive approach has received most attention and the evidence is so compelling[2].

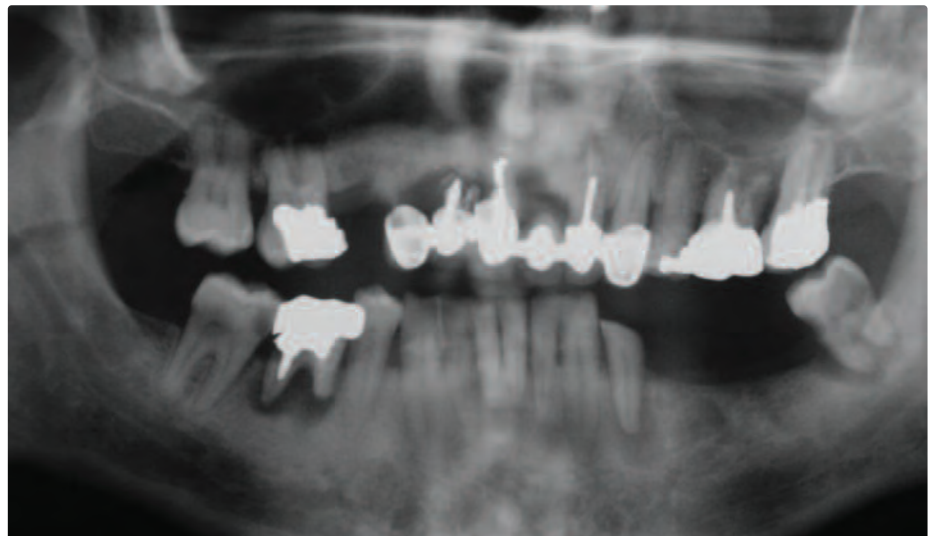
Dentures

Despite even the most robust of preventative regimens, some patients will still require extractions. Many of these patients will go on to request dentures. Some will have pre-existing dentures that may "no longer fit". There are potential clinical difficulties in providing dentures for the elderly with which some of us deal better than others. This is not a valid excuse for providing inadequate care or a lack of knowledge, however, and practitioners need to prepare their teams for such changes.

Accommodating frailty

In the paper written by Richard Porter[2], we are reminded that there is never an excuse for neglecting to address treatable dental pathology; a complex medical profile, ill health, or a lack of tolerance for lengthy appointments. However, with the mouth held wide open, it may mean that sensible clinical compromises are appropriate.

This is not an excuse for avoiding treatment. An open-minded discussion to cover all options will help the clinician gauge what changes to the delivery of treatment might be required by the ageing patient in their chair.



[1] Kelleher, Martin : Minimally destructive aesthetic dentistry: *Riskwise UK* 33; 2007

[2] Porter, Richard: The population is ageing: *Teamwise New Zealand* 10; 2014

Changes in culture: prevention and minimum intervention

When it comes to lifelong care, the dental team is in it for the long haul

Investigate. Mitigate. Facilitate. Validate

Change in demographics and prevention

It is a sobering thought that, of all the babies born now, one in three will live to be a hundred. This is in stark contrast to years ago, when medicine and living conditions might not always have contributed to such longevity. So, what of it? This has implications on healthcare and, of course, dentistry. Population numbers are just one of the factors that affect the way in which we practise medicine and dentistry. Longevity means that, as well as our patients regularly returning over the years, so are their teeth!

Extend not for prevention

Internationally, modern teaching has adapted to this change, driven by evidence-based research. The technique originally adopted for amalgam has given way to the new paradigm of minimally invasive dentistry. It is not so much about dentists doing less, but rather it is more about intelligent dentistry.

New materials and changes in skill set

There has been a shift in the skill set of dentists. Patient care might now involve repairing restorations rather than cutting new areas of tooth tissue. There has also been an expansion in the range of available restorative materials, as well as an international decision to phase out amalgam. Many years ago, the constant starting and stopping of air turbines could sound like an orchestrated whistle emanating from the surgery. Now, there is less drilling and more emphasis on prevention. The reactive approach has become pro-active at last.

Ethics

"First do no harm" sits at the core of the dental profession's thinking and approach; the best form of dentistry is that which is the least necessary to meet our patient's needs. For consent to be valid, the clinician has an obligation to present the patients with all the available options to address their needs. In addition, the financial constraints of third part payments will impact on the treatment decisions made by the patient. Discussions about costs and payment also forms part of the consent procedure.

Consent

Valid consent remains a constant in a world of change.

Two treatment extremes:

Case study 1

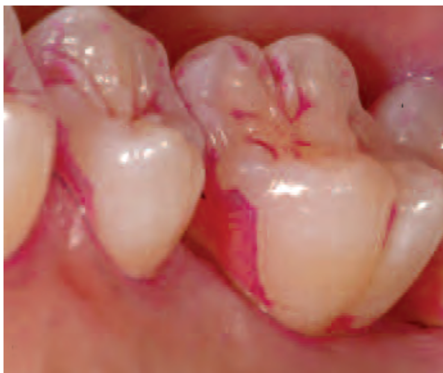
A young dentist saw a patient for an examination and X-rays before devising a treatment plan. A risk assessment of the patient's lifestyle was made, as well as the decision to monitor non-cavitated carious lesions. The patient was given advice on diet and the need for regular examinations. She was also prescribed high fluoride toothpaste.

After six months, the patient saw another dentist who informed her that she needed four fillings. The patient was surprised and sought legal advice. When Dental Protection reviewed the records, it became clear that the rationale behind this approach had been explained to the patient in some detail. The patient eventually recalled the conversations with the dentist, and the case now became defensible. It is recognised that it is possible to arrest – and even reverse – the mineral loss associated with caries at an early stage, before cavitation occurs. Enamel and dentine demineralisation is not a continuous, irreversible process.

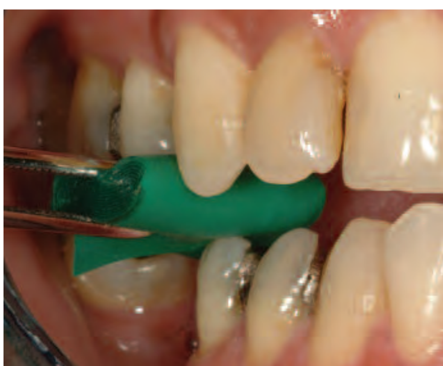
Case study 2

A dentist decided to treat what looked like a small gap between a filling and the tooth with regular applications of fluoride varnish. After three months, the patient presented with pain. On further investigation, a diagnosis of irreversible pulpitis was made and the tooth needed a root filling. This case was *not* defensible, as there had been inadequate investigations. In addition to this, the treatment was inappropriate. We all see things differently – dentistry is no exception.

What is important is to make a risk assessment and to treat the *specific* patient. Experience, intuition and working in the patient's best interests inevitably form part of the decision-making process. By, involving the patient in all decisions – and giving them enough information to understand their treatment – you will validate their consent.



Case study 1



Case study 2

Evidence-based practice

Play "detective" in your role as a clinician and you are on the right track – but there is always a need to keep abreast of the shift in gears and not "keep on doing what you've always done"

Shared characteristics of great detectives and clinicians[1]
- Ability in observation
- Ability in 'deduction'
- Knowledge
- Ability to reconstruct psychological and social profiles
- Ability to spot inconsistencies.

There is evidence that Sir Arthur Conan Doyle's inspiration behind Sherlock Holmes was the physician, Dr Joseph Bell whose famous deductive reasoning had so impressed him as a medical student.

Dr Bell certainly used evidence to support his clinical assessments. A skilful blend of observation and reasoning produced diagnostically useful information. Evidence-based care was still some way off, so the scientific basis for some clinical decisions remained somewhat elementary.

Both Dr Bell and Mr Holmes used evidence as if they were detectives. The facts acted as a marker of past events; a diagnostic aid to establish what had already happened. This is the same process used by the clinician when taking a clinical history.

It is essential for the clinician to ensure that the intended outcome of a course of treatment is based on sound evidence. None of us wants to deliver care that doesn't work. This is why we always do the right thing - or do we?

Comfort zone risks

We all have our own comfort zones when using familiar techniques. There is nothing intrinsically wrong with this fact, but comfort can also create a barrier to change. Colleagues will already recognise the importance of keeping their knowledge and skills up-to-date. You were perhaps "on top of your game" last year/when you qualified/when you got your first job/when you did the course. But, we shouldn't forget that the knowledge upon which effective clinical practice is based is also constantly evolving. Without realising it, we can fall behind the most recent developments.

Although there may not be much obvious change from one year to another, there can be a gradual creeping shift. (see Biomaterials, page 42).

Techniques and approaches are modified and assimilated into accepted best practice. A clinician's own favourite, familiar approach may appear to work well enough, but without a review, just how effective is it and does it really get the best results?

Keeping up to date

The use of an evidence-based approach assumes the premise that treatment decisions should be based, as far as possible, on a body of evidence, taking account of the available knowledge from the scientific literature to determine best practice. In this way, decisions about clinical activities from hygiene advice and preventive treatments through to complex restorations, drug prescribing and implant placement will have a secure foundation which will serve both the patient and clinician well.

Clinicians have access to a range of guidelines published by various professional bodies and specialist organisations. Guidelines are produced – and reviewed – by a recognised body of experts in the field. The difficulty for the average, busy practitioner is that published guidelines rarely make it clear whether the stated standards nearest the reasonable standard expected of the reasonable competent practitioner, or perhaps something for them to aspire to over time. This is an unhelpful omission by those who produce such guidelines. The clinician who follows such professional guidance will in any event be acting in accordance with a body of carefully weighed evidence, and may well be exceeding the required "reasonable" standard by a wide margin.

[1] Rapezzi,C and Branzi, A : White coats and fingerprints: diagnostic reasoning in medicine and investigative methods of fictional detectives *BMJ.* 2005 Dec 24; 331(7531):1491–1494

Changing attitudes to healthcare professionals

A higher life expectancy will inevitably lead to increased financial pressures. So, how best to ride the wave of change and balance mounting costs and third-party interests against delivery of care

The survey says...

- Many studies confirm that healthcare professions in general (and doctors, in particular) are amongst the best trusted members of society
- A 2011 survey – carried out in the UK by one of the most respected independent sources of information on public opinion in the UK (Ipsos MORI) – confirmed that doctors were the most trusted profession of all, with 88% of the public saying that they could be trusted to tell the truth
- Conversely, politicians are at the very bottom of this league table with a trust rating of only 14%
(Ipsos MORI survey; UK 2011)

Healthcare is never far from the centre of society's preoccupation, nor from the top of the political agenda. Like it or not, healthcare is big political business. It affects every member of society in one way or another and, at some stage in our life, we will all find ourselves in the clutches of the medical profession.

Of course, healthcare is expensive – and that isn't likely to change any time soon. As it evolves and develops, it enables people to survive many of the diseases and conditions that would have proved terminal for previous generations. In doing so, they will cost further money later in life. While that sounds like success – especially for those living longer and enjoying a better quality of life as a result – it creates a big problem for governments around the world who have to figure out how to pay for it all.

Searching

People have a greater life expectancy and they receive more expensive treatments along the way to prevent, cure or manage their conditions. As a result, their healthcare needs tend to increase as they get older. Governments and third-party healthcare funding organisations (whether insurance-based or mutual health funds) are continually searching for ways to contain the spiralling cost of healthcare and to secure the best possible outcomes at the lowest possible outlay.

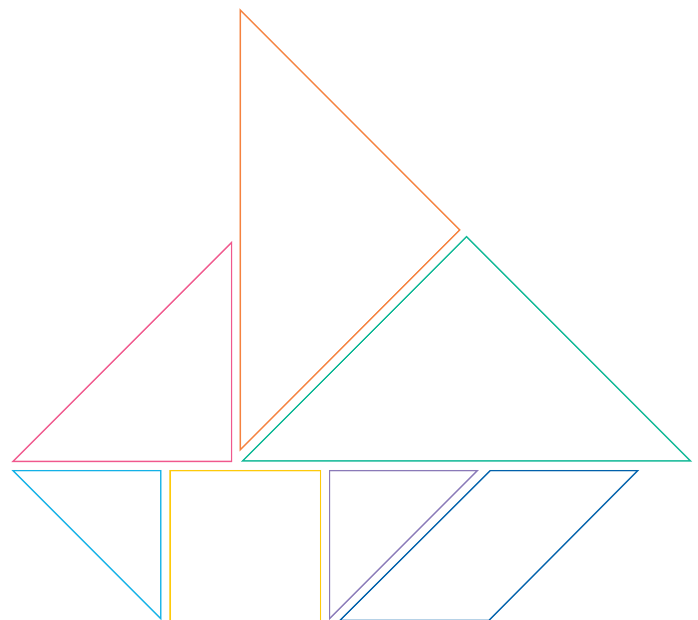
This search has, not unsurprisingly, uncovered many of the same solutions that the world of business outside healthcare – such as the manufacturing industry – discovered a long time ago.

Imbalance

The historic strength of the relationship between clinician and patient has always troubled governments and anyone else whose money is being spent on what happens within that relationship. And so, they have come up with ingenious strategies to weaken and destabilise that relationship when they see it becoming too cosy and having far too much influence and control over the treatment decisions and, therefore, the ultimate cost of all that treatment.

The problem for the people whose money is being spent is that most patients trust healthcare professionals – especially *their* doctor, *their* surgeon, their dentist – and that relationship is stronger and closer than with the third party in the funding relationship (whether that is a government agency, an insurer, or some kind of health fund). This imbalance of influence creates what health economists refer to as a "relationship monopoly".

Most patients trust healthcare professionals



Tentacles

One of the main battlegrounds to witness some of the greatest conflict has been managed care. This had humble origins in the USA in the early 1970s but became prevalent in medicine as consumer (patient) demand grew at the same time as new technology began to make its impact.

As costs predictably spiralled upwards, managed care grew into a behemoth of giant proportions with its tentacles reaching across the world. The central theme was that of establishing a set of rules that determined what treatment could be provided, how often, to which patients, under what circumstances, and so on. It was driving a deliberate wedge between healthcare providers and the patients receiving the care and treatment.

Co-payments were used as a tool to put a brake on patient demand and caps were introduced to limit how much healthcare patients could access in any one year. Preferred provider arrangements helped to drive down fees in return for assured compliance with the rules of the scheme and the lure of relatively assured patient flow. But there was also a fear expressed that the only real beneficiary was the third-party funder that got a predictable amount of treatment carried out for less money. Meanwhile, the provider forfeited profit margin and struggled to provide the same quality of care with less money to pay for the time, facilities and resources. And the patient was the recipient of treatment provided within those constraints.

Any failings in the delivery of healthcare will always be big news

Territory invasion

A more recent phenomenon has been the appearance of a new threat to the historic autonomy of the patient-clinician relationship – the professional manager. Taking the form of a hospital manager or, perhaps, a regional manager of a corporate group – or even, simply, the manager of an individual practice, this is a variation on managed care because this becomes a much more direct invasion of the territory once the preserve of the individual clinician. It can extend to a clinician's choice of materials and equipment, instrumentation, dental laboratory and can even extend to instructions as to referrals or specific types of treatment that need to be "promoted". Somewhere along this continuum, most readers will have been thinking "that's a step too far", but you can be certain that dentists somewhere in the world will be experiencing all of these situations on the very day you are reading this article.

Feeding frenzy

Healthcare will always be in the spotlight – and any failings in the delivery of healthcare will always be big news. The interesting thing is that the Ipsos MORI survey in the UK (see panel on page 33) was carried out against the background of some major healthcare scandals that had spawned something of a feeding frenzy by the media on any "bad news" healthcare story. So, to end up topping the "trust" league table after all that was no mean achievement.

Dentists did not form part of that survey but, two years later, UK dentists did come out ahead of doctors in a poll conducted by Bray Leino. At around the same time, research conducted by the UK's regulator, the General Dental Council, revealed that 94% of dental patients were confident their dentist treats them fairly. But governments, third-party funders, regulators and some consumer bodies can fall short of illustrating that they understand – or share the trust – in the medical and dental professions that shines through so strongly in most of the patient surveys published.

Sometimes, they don't even accept or believe the findings of their own research. Is it that they don't believe it, or rather they prefer not to believe it? Or, do they simply think the public has got it wrong? If so, that "relationship monopoly" has a lot to answer for.

The last word

Before leaving this topic, we must also recognise that governments and third-party funders do not see "healthcare professionals" as solely "doctors and dentists". The diversity of the healthcare workforce – in both medicine and dentistry – is seen as one of the keys to squaring the circle of what currently seems to present an impossible long-term funding challenge.

Universal healthcare in the future probably is unaffordable if all of it needs to be delivered by doctors and dentists; the opportunity being explored in many countries is that of making greater use of the expanded workforce, widening their scope of practice and taking down some of the historic legal and regulatory barriers.

Doing this at the same time as shortening training, improving quality and patient safety, and widening patient access to healthcare services is a challenge. And, if there is to be a financial dividend, it is clear that governments, dentists and practice owners, the members of this expanded dental team and, not least, patients all want and expect to be the beneficiaries – and that really is one area where the sums – as yet – fail to add up.

Changes within the dental profession

Dental physician, surgeon and educator? 34
Overstepping boundaries? 35
Team working 36
Standards, competency and specialisation 37

Dental physician, surgeon and educator?

The complex interface between medicine and dentistry

People everywhere are living longer, according to the World Health Statistics 2014. Based on global averages, a girl who was born in 2012 can expect to live to around 73 years, and a boy to the age of 68. This is six years longer than the average global life expectancy for a child born in 1990

As members of the dental team, we are trained to regard the patient holistically and treat people – not just their teeth. Central to this is the need to understand the patient and this places on the dental team a need to:

- Record medical history
- Learn social history (including such things as exposure to sunlight or sunbeds)
- Record past dental history
- Update the record of all medications and drugs the patient is taking (both prescribed and recreational)
- Note current and past nicotine and alcohol intake.

All this information is noted and assessed so we can recognise the implications certain drugs and medical conditions will have on the provision of care, their interactions and the effects this may have on the teeth and supporting periodontium.

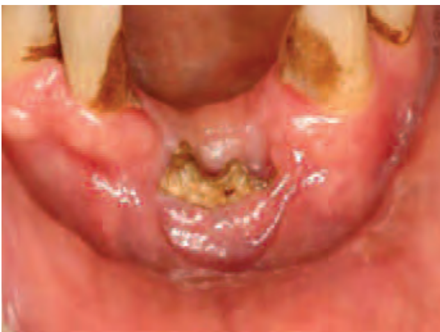
More than ever before, patients are living longer – many with serious medical and mental health conditions, and will be seeking regular maintenance treatment in primary dental care often as part of a wider multi-disciplinary team. For example, patients on anticoagulants who, in times past, would have been referred for hospital care can now have their INR tested within the surgery and a decision made to proceed with an extraction there and then.

Preventive care now has to be delivered to older patients with a wide range of ability and possibly reducing mental capacity. The general dental practitioner also has an on-going role in the tertiary prevention and lifelong vigilance on behalf of patients following treatment for cancer. This includes an urgent referral for any patient with a suspicion of recurrence or a new primary malignancy.

The onus is on the dentist to combine the skills and approach of a physician, rather than simply acting as a surgeon, in order to examine and record both positive and negative findings following a thorough history taking and inspection extraorally and intraorally of the patient.

Clearly, far more is expected now than simply attending to a patient's dentition.

Case study 1



Courtesy of Dr. Stephen Flint

Case study 2

Case study 1
An example of heightened vigilance

A patient who had been a habitual smoker had managed to quit and was being seen regularly by his periodontist. At one visit, she remarked on the patient's hoarse voice. The patient reported it had been like that over several weeks and so he was advised to visit his doctor who prescribed two courses of antibiotics which were of no benefit. At the next visit the periodontist remained concerned that the patient's voice was no better and so she advised he should return to his doctor and insist upon a referral.

Carcinoma of the larynx was diagnosed and a total laryngectomy followed. The patient was very grateful for the vigilance and care provided by the dentist, especially that no radiotherapy was required. His dentition, though compromised, was retained as a consequence of the good care provided.

Case study 2
A lack of care and up-to-date knowledge

An elderly patient had an extraction and, despite numerous visits complaining of acute pain from the extraction site. It was not until he sought advice elsewhere that a referral was made and the diagnosis of bisphosphonate-related osteonecrosis of the jaw was made. A complaint was investigated that identified a medical history had neither been taken nor updated. This was significant as the patient has been taking a bisphosphonate for many years and good practice guidelines had not been followed.

Overstepping boundaries?

The purpose of setting a healthy boundary is to protect interests but this doesn't necessarily stop you breaking down walls

Pushing at the boundaries of dentistry

Before undertaking procedures that arguably go beyond the traditional boundaries or scope of your profession you need to;

- Have a sound understanding of the scope set by your regulator and how this might impact on your statutory rights to lawfully prescribe medicines for boundary-pushing procedures
- Demonstrate you have completed appropriate training to carry out the procedures safely, successfully and in line with the law and regulated professional standards
- Have appropriate indemnity arrangements in place to protect the patient, as well as yourself, in this respect. There can be variations in the specific regulatory requirements of each country
- Ensure your patients are given sufficient information about the treatment, its limitations, alternative mainstream procedures, and any other healthcare profession or speciality that might be better suited to carrying out the procedure.
- In order for their consent to be valid, patients need to be informed about your competence to complete the procedure.

Dental teams increasingly seek out new and innovative ways to meet the demand for modern or even cutting-edge treatments; and explore ways to differentiate themselves from the competition. More patients than ever before demand more than just the treatment of dental diseases. Some may even expect life-changing results, particularly with the perceived benefits associated with the marketing of cosmetic and implant treatments.

Not all of us have the skills and patient management experience to be successful in the delivery of such care. Traditional undergraduate teaching is unlikely to provide the necessary skills to undertake, for example, the provision of non-surgical cosmetic/aesthetic procedures. Nor indeed, training in the use of short-term rapid sectional orthodontic procedures – or even basic implant training. Yet these procedures are high on the wish-list of many patients. So, when the beneficial outcome of the treatment meets the expectations of your patients, these reputation-enhancing procedures can also generate income streams and deliver good levels of professional satisfaction.

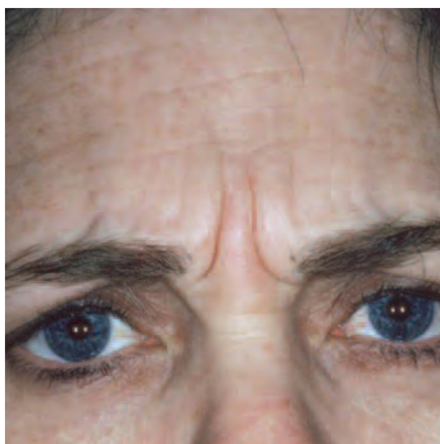
...and beyond

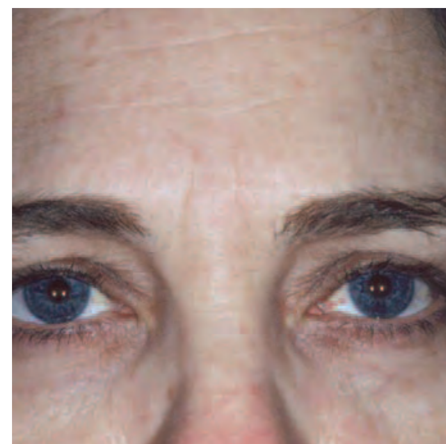
It has been argued that dentists are better placed to carry out and achieve success with non-surgical facial cosmetic and adjunctive procedures. After all, they have a good understanding of facial anatomy and dento-facial aesthetics possibly better than most other professional disciplines. Once confidence and competence grow, it is tempting to undertake procedures beyond the oral and peri-oral areas including around the eyes, the nose and the forehead. The more adventurous may even think of venturing into the neck and beyond – in some cases, oblivious to the much greater risks to which they are exposing themselves and their patients. In such a case, when does the procedure stop becoming the practice of dentistry and become the practice of something else altogether?

Professional regulators around the world frequently define the boundaries of the practice of dentistry or more commonly set guidelines that determine the scope of the profession. The same applies to hygienists, therapists and other dental health professionals. In most jurisdictions, the scope will define any variation in the treatment boundaries required for each group.

To push the boundaries beyond one's professional scope does not mean you are no longer regulated for that activity. A dentist or a dental care professional must apply the same standards and ethical behaviour to whatever activity or service they are providing. They also need to be prepared to accept the consequences of a regulator showing an interest when a complaint arises or a claim for clinical negligence is forthcoming in an activity where clinical boundaries have been exceeded.

Some patients expect life-changing results





Team working

The successful delivery of dentistry relies on professional dedication and expertise, achieving shared goals – and good support

On Sunday 13 July 2014, two teams of 11 men ran around a field in Brazil in an attempt to kick a ball weighing 14oz into a space measuring 8ft high x 24ft long. The spectacle was witnessed on TV by an estimated 1.1 billion people. The event was of course the 2014 FIFA World Cup final. Although the game itself only lasted 90 minutes, the amount of time spent by the media discussing the tactics and make-up of the Argentinian and German teams far exceeded this.

Devoted

Many newspapers devoted several columns of analysis to this, too. The fitness and availability of key players prior to a crucial game was discussed at length. The implications of player transfers between clubs – in terms of team strength and weakness – can draw out opinions around the globe. The ramifications of a change in personnel on the dynamics of the team are well recognised. Fielding 11 strikers and no goalkeeper is not a tactic likely to bring success. The concept that dentistry is a team – rather than an individual – effort is potentially misguided. When viewed from the outside, perhaps through the eyes of someone who has only ever experienced dentistry as a patient, the whole industry may appear one-dimensional, straightforward and, possibly, somewhat boring. Those of us within the profession would almost certainly have a different view.

Expertise

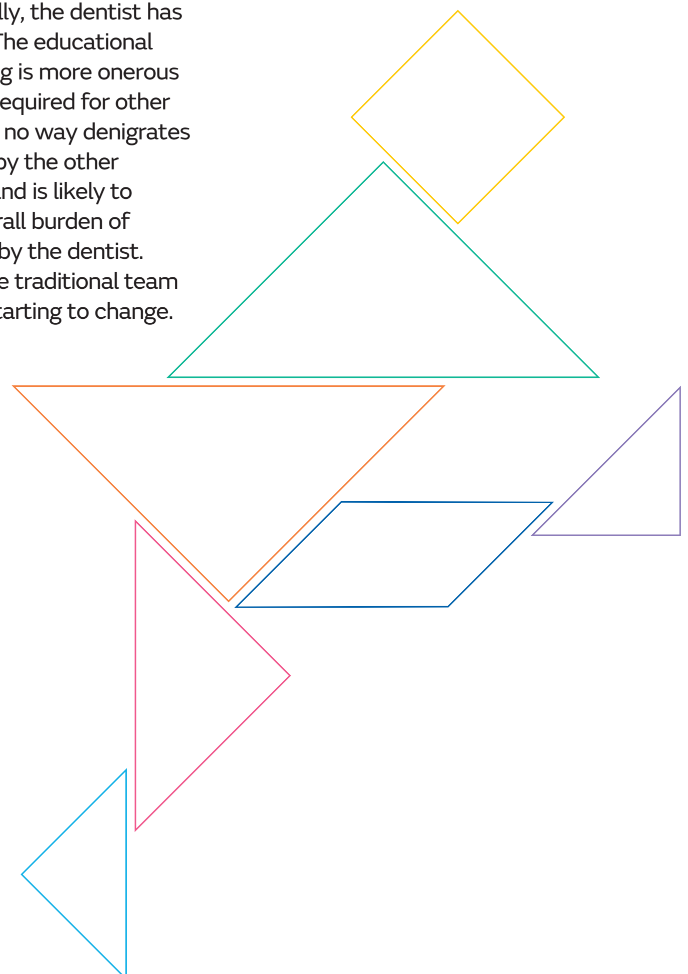
Most patients are unlikely to be satisfied with treatment that only offers extractions and dentures as the sole solution to their dental problems. The current complex delivery of patient care is only possible by calling on the expertise of team players, each with their own individual contribution to make. The immediate team may comprise dentists, dental nurses, dental assistants, hygienists, therapists, technicians, practice managers and, reception and administrative staff. The wider team may include hospital services providing secondary or tertiary care in addition to specialist practitioners who are able to more appropriately deal with certain cases beyond the training, skills and expertise of those in general dental practice.

Tactics

Underpinning the clinical team, there may be financial and management advisers and other financial service providers that support the business side of dentistry as well as, of course, the defence organisations that provide support and advice when the treatment does not go according to plan. A team is at its most effective when all the players know their roles and appreciate exactly what is expected of them. Their focus will ensure the patient's interests come first. Putting those interests before those of the treating clinician is all part of being a health professional. Traditionally, the dentist has been the team leader. The educational attainments and training is more onerous for a dentist than that required for other team members. That in no way denigrates the contribution made by the other members of the team and is likely to be reflected in the overall burden of responsibility assumed by the dentist. In many countries, these traditional team dynamics are already starting to change.

Extra time

Many dentists relish owning their own practice and are happy to take on the additional responsibilities. They may feel secure in the knowledge they have complete control over the entire patient experience. There are others who are willing to embrace a more holistic approach to dentistry by better utilising the skill mix within the wider dental team. In some jurisdictions, direct access to dental care professionals – such as hygienists and therapists – is allowed within the law and associated regulations. By utilising the whole dental team in this way, the dentist has additional time to concentrate on more difficult and complex treatment. It may well be that some dentists do not wish to totally immerse themselves in difficult and demanding treatment and may want to balance such cases with some of the more routine aspects of delivering patient care.



Standards, competency and specialisation

Tread cautiously before being engaging with innovation

Before offering new treatments, ask yourself...

- Do you meet the criteria expected in academic study and training?
- Have you learned treatment techniques under supervision?
- Do you know the level of your competency?
- Are you open with patients about the implications of choices available?
- Do you always refer to a specialist when necessary?
- Do you make a referral to a specialist who is on a relevant specialist list maintained by your regulator/registration body? If not, what steps have you taken to satisfy yourself as to the person's training, experience and ability?

Flat screen televisions were once the preserve of the wealthier consumer. But, over time, the relative costs come down to the point that they have become more generally affordable. So it is in dentistry.

Implants – once the preserve of the very few - are now an almost everyday part of general dental practice in many countries. Equally, operating microscopes – once seen only in operating theatres and associated with micro-vascular surgery and later in specialist endodontic practice – have along with operating loupes, found their way, into some general practices.

Conversely, what was once expected of the "safe beginner"[1] in practice, i.e. experience of numerous dental extractions and the provision of difficult amalgam and gold restorations as well as the provision of many sets of complete dentures has tended to become the preserve of the specialist. Today's safe beginner is much more conversant with posterior composite restorations, using minimal interventive techniques, and the safe use of rotary endodontic files and warm gutta percha. They have experience of modern dentistry - but not very much of it.

Trailblazers

Every profession needs trailblazers to push the boundaries of knowledge and to explore the potential of new materials and, typically, these will often be specialists or academics. Without early adopters – both in academia and, in some countries, beyond the teaching environment – these developments would almost certainly remain the preserve of those who undertake the research. In an era of evidence-based practice, a significant body of evidence is necessary before state-funded support for these new techniques becomes available.

At the same time, the expectations of the public and the regulators (Dental Councils and Boards) are reflected in the revised standards that govern the dental profession. The dental profession in many countries recognises areas of specialisation, developing curricula of study that evolve as new techniques are incorporated.

Entry point

Regulators are developing increasingly sophisticated decision-making tools to determine what constitutes a reasonable entry point for specialist lists in those countries that have them. The entry points are sensibly developed in conjunction with the training establishments who can inform these decisions. Entry is based on the achievement of both academic study and training, with treatment techniques learned and perfected under supervision. These standards are necessarily high, giving regulators – and the public – confidence that specialists are worthy of that title. Over time, the specialist training curricula are modified and, where suitable, they are incorporated into undergraduate training and mainstream primary care.

The challenge for any clinician is to know their limitations and to be candid with their patients about the implications of each of the choices available. Insight and honesty are key to any communication about choice, particularly in times of economic hardship where it may be tempting for both the patient and the generalist (albeit for different reasons), to avoid a referral to a specialist. Both parties need to understand the risks of the decisions they take.

Locality

In favourable economic times, many general practitioners would refer anything but the very simplest endodontic treatment to those in the locality skilled and expert in contemporary techniques. The consequence of this was that many generalists de-skilled and did not keep up to date with the necessary skills and equipment used in modern endodontics.

Economic recession leads to patients expressing a preference not to be referred because of the cost. This sometimes leaves the generalist feeling obliged to offer treatment when, in their heart, they know they are not currently competent to provide some of the newer treatment techniques safely and to a high standard.

Whilst the starting point for such a dialogue may be designed to save the patient money by avoiding the short-term cost of a referral, the judgement is whether any attempt by the generalist to undertake quite complex treatment would be regarded by a reasonable body of colleagues as being sensible in the relevant circumstances. A similar conversation could equally apply to oral surgery procedures, implant placement, complex prosthodontics and many other clinical scenarios. In endodontics, unfortunately, the harsh reality of a suboptimal outcome is visible on any post-operative x-ray and serves as a permanent reminder of an unwise decision.

Economic recession causes some patients to express a treatement preference based on cost

[1] A new dental graduate

Changes within clinical dentistry

Equipment and the working environment 39
Imaging 40
Dental implants: asset or risk? 41
Biomaterials 42

Equipment and the working environment

In the 21st-century, innovation and development are very much an integral part of our professional lives. But, teams are often faced with difficult decisions on how best to incorporate these new technologies into practice

Equipment in a digital age

- Innovations can be expensive so be certain there's a proven benefit before undertaking a large capital outlay
- Take a balanced view of new equipment when visiting manufacturers' stands at dental trade shows
- Always be sure you are trained and competent in using the new technology
- Don't get rid of the older style equipment immediately – sometimes, they have an established reliability which you may need to fall back upon
- Incorporate new technology or processes into the practice gradually until the team is competent in using it
- Job shadowing or having a mentor helps to achieve this competency.

Dentistry is particularly reliant on equipment and that presents its own challenges in many different ways. Dental teams need to be alert to these changes as they can offer benefit to patients. As a dynamic profession, we all constantly seek improvement in the way we do things. The arrival of the digital age has seen the introduction of new equipment that can challenge and even change the way we have traditionally carried out many procedures.

Equipment technology can provide us with assistance to do our jobs more easily and effectively whilst information technology, such as computers, has aided us enormously in recent years, particularly when it comes to record keeping. Technology can make our clinical tasks easier and more predictable. One only has to think of the developments in magnification with loupes to see how this has allowed us all to see in more detail the tooth we are working on. For many dental teams, new equipment can improve the quality of the working environment and the enjoyment of the job.

Possibilities

The introduction of new equipment and its acceptance into mainstream practice is variable and driven by a variety of factors. For example, it took just two years for air rotor handpieces to gain widespread adoption, yet it has taken 25 years for implants to become routine in general practice. Additionally, the advent of CAD/CAM (computer aided design/ computer aided manufacturing) creates possibilities many of us couldn't have imagined. Sometimes, these innovations can be expensive and the prudent business owner will look for evidence of a proven benefit before undertaking a large capital outlay.

It is important to take a balanced view with some of the new developments when visiting manufacturers' stands exhibiting their latest equipment at the numerous dental trade shows. Cone beam CT is an exciting technology that has become the standard for many techniques such as implant placement and other aspects of oral surgery. But in our eagerness to embrace new technology one must be careful not to forget the advantages of traditional radiography and the reduced radiation dose that is associated with digital techniques.

Mentor

Evolving techniques and equipment can throw up new challenges and it is important to ensure that, as responsible professionals in our field, we undergo adequate training to gain the experience needed. The idea of shadowing a colleague or having access to a colleague as a mentor is a well-accepted way of developing a good working knowledge of new equipment.

Indeed, it is prudent to ensure you are competent with the new equipment before dispensing or replacing old equipment. If you are introducing a new apex locator to establish the working length of a root canal, for example, it might be wise to keep taking working length radiographs for a short period to confirm the working length and make sure that your device is accurate and correctly calibrated.

Although we all have an idealised vision of how dentistry could look in the future, often the reality is quite different and we could well discover we have to rely on tried-and-tested techniques for a little longer. Advances in equipment offer many practical benefits to the dental team – and exciting opportunities. Ultimately, it will be the demonstration of an improved quality of care for our patients that will tip the balance and allow us to move on.

Imaging

Excellence in dental diagnosis and treatment is essential to the progression of dental care. But, the integration of any new modalities should never overshadow clinical integrity

Key to success
- Select the right image for the job at hand
- Interpret it accurately
- Get a second opinion if unsure
- Record what you see – even if there is nothing abnormal
- Keep up to date with the new developments and applicable regulatory standards.

Radiographic imaging was discovered by accident less than 120 years ago. This was around 70 years after the first developments in photography. Both techniques form an integral part of the assessment, treatment planning, diagnosis and record keeping processes in dentistry. The digital age has been the driver for a step-change in further development – to a point where the clinician can see and record any function or structure within the human body, at any time and be assisted in visualising it in three dimensions.

When considering imaging in a dental setting, it is important to keep in mind what you are trying to record – and why. While some treatment modalities require a specific and detailed set of images, this will only apply to specific patients. In broad terms, a standardised list of photographic and radiographic images taken for every patient – regardless of their clinical needs – will often lead to unnecessary images being taken with no real diagnostic benefit.

Frequency

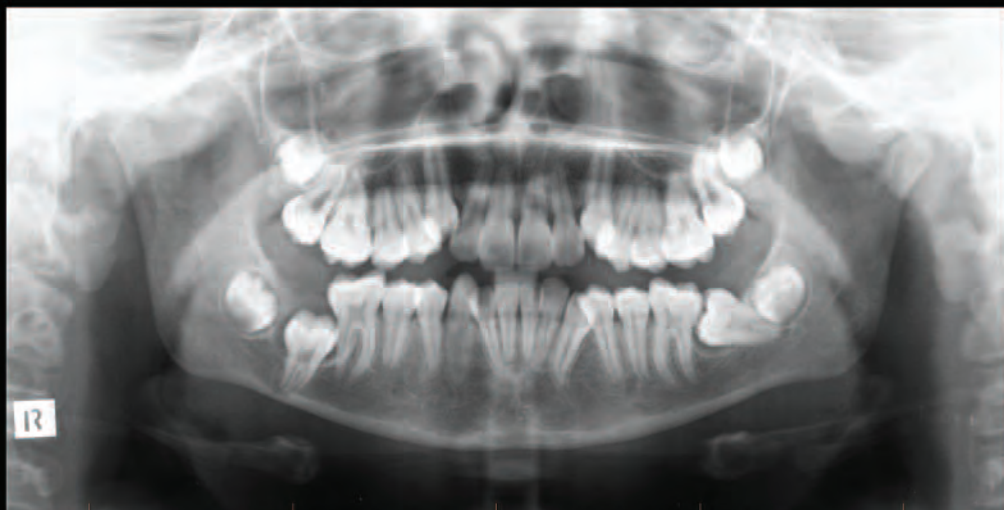
To prevent over-prescription, learned bodies have produced guidelines that recommend an appropriate frequency of repeat imaging to ensure, for example, that radiographs are taken at appropriate intervals to avoid being accused of under-diagnosis and under-treatment. Such a situation arises when a practitioner fails to notice the diminishing bone levels, indicative of periodontal disease that may have easily been identified had appropriate images been taken at appropriate intervals.

As the technology of dentistry advances, so too does the clinician's need for better – or more detailed – imaging to support the diagnosis and treatment and to make the outcomes safer and more predictable. Old systems can be updated and modified, or replaced altogether with new imaging modalities, and there are plenty of systems available that offer a user-friendly interface with what might initially be unfamiliar technology.

Cone beam tomography (CBCT) gives the clinician the capacity to virtually "walk" through the patient's oral cavity and view them from every angle. However, the treating clinician should always consider whether all this information is actually needed in order to create the treatment plan for every patient.

Some points to consider:
- Is a 360-degree view required every time?
- When you have all of this information available, are you analysing it fully, thoroughly and accurately? Are you trained and competent in this analysis?
- Is it possible you may not be able to diagnose pathology in adjacent structures in a panoramic x-ray that would be clearly visible to an expert in this field?

The plethora of available choices can leave the clinician at a loss regarding what to opt for. Indeed, selecting the most appropriate image type required for pre-operative assessment can be a moveable feast dependent upon both the procedure and the jurisdiction – and perhaps, the patient. Dental Protection has assisted many members who have been using a standard pre-operative imaging regime without adverse incident for many years, only to find that the world around them has moved on, and they are no longer meeting the expected standards. If we fail to embrace new technology the time comes when we become vulnerable to the allegation that an undesirable outcome could and probably would have been avoided, if only we had taken that extra step and moved with the times.



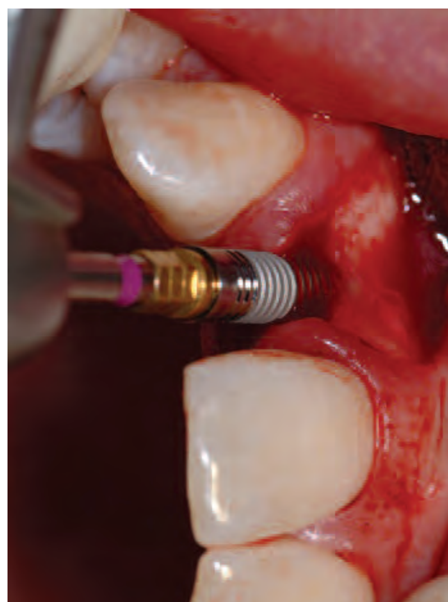
Dental implants: asset or risk?

Patient demand for dental implants has increased – but major advances are not without risk. Indeed, litigation in this field is increasing...

The introduction of dental implants is one of the most significant and exciting changes in modern dentistry. Brånemark placed his first titanium dental implant in a patient in 1965 after discovering osseo-integration. Since then, techniques have been refined and healing times reduced, due to advances in implant design and improved knowledge derived from research.

Training

The planning and execution of treatment involving dental implants requires a knowledge and skill unlikely to be developed at undergraduate level. Reputable training programmes are essential. Some dental implant manufacturers lead us to believe that anyone can place and restore dental implants with short training programmes. This is clearly not the case, and an experienced mentor should be available to provide valuable advice and support for those new to this field.



Planning

Treatment planning has become more sophisticated with the introduction of CT scans and 3D technology. Diagnostic wax-ups, and the use of computer imaging to create 3D surgical models of an individual patient are used to plan the treatment and to envisage and demonstrate the eventual aesthetic outcome. As expectations increase, the need and demand for these tools will also increase. Practitioners who still use 2D imaging for complex cases are exposing themselves (and their patients) to unnecessary risks in many instances. Equally, the use of 3D imaging without a specialist radiologist's report could lead the dental professional to unwanted litigation if, for example, a tumour is subsequently found to have been present, but was unrecognised because the clinician's mind was on the implants or simply because its recognition was beyond the clinician's expertise.

Implant quality

Some dentists are attracted to the field of dental implants partly because it is seen as being a profitable income stream that will continue to grow in the years ahead. However, the appearance of so many new companies providing shorter and shorter implants should ring alarm bells for the responsible practitioner looking for evidence-based reassurance. Many of the newer implant systems may not be sufficiently "tried and tested" and have the necessary support if the result is sub-optimal. If in the years ahead there is no dependable source of components to maintain and repair them, the clinician's choice of system may well be called into question – just as has happened in many medical surgical fields.

Immediate implants and grafting procedures

Immediate loading and restoration of dental implants is more predictable in the hands of experienced practitioners. Many of the bone grafting materials, now available are very technique sensitive. Careful patient assessment and valid consent are essential.

Implant failure

Peri-mucositis and peri-implantitis are becoming increasingly common as more implants are placed and they are already creating some significant challenges. Initial success rates are reportedly around 95%[1]. However, late failure is increasing. Tobacco smoking[2] and on-going periodontal disease[3] have been linked with these failures. Supportive maintenance care for implant patients is essential and with well-trained dental hygienists a team approach is likely to be the most successful. Instrumentation should be "titanium-friendly" to avoid scratching the implant surface. Calculus removal on exposed implant threads is probably the more important factor though. Pre-operatively patients should be warned of the risk of failure without adequate aftercare and these warnings carefully recorded. Bone levels should be monitored to identify implant failure at an early stage.

Other complications

A failure to assess a case in sufficient detail, and to plan for the execution of each phase of the treatment can lead to a large number of unwanted and costly complications. Incidence of mental or inferior alveolar (dental) nerve damage is surprisingly high without adequate pre-operative assessment and good quality imaging can help to reduce the risks as part of a surgical plan. In the maxilla, the presence of a stray implant in the sinus is not uncommon if inadequate bone is present or primary implant stability not achieved.

Conclusions

Dental implants are an amazing development in clinical dentistry and can produce life-changing results for our patients. However, they are certainly not without risk and some of the associated claims can be very costly indeed. Dentists should ensure their indemnity arrangements accurately reflect the nature of the clinical work being undertaken. Dental Protection would suggest discussing this with our membership team and seeking our advice early if unwanted complications occur.

[1] Berglundh, T.; Persson, L.; Klinge, B. "A systematic review of the incidence of biological and technical complications in implant dentistry reported in prospective longitudinal studies of at least 5 years". *Journal of clinical periodontology 2002 29* (Suppl 3): 197–212

[2] Bain CA, Moy PK. The influence of smoking on bone quality and implant failure. *Int J Oral Maxillofac Implants* 1994;9:123. 20

[3] Baelum V, Ellegard B. Implant survival in periodontally compromised patients. *J Periodontol 2004*;75:1404-12

Biomaterials

A fundamental knowledge and understanding of dental materials is essential, but so too is the need to share this knowledge with patients

Amalgam – it's all in the mix

- In some jurisdictions, the use of dental amalgam is being gradually phased out. This decision formed part of an international agreement addressing environmental issues, rather than responding to intrinsic concerns about the safety of the material per se
- In countries where the use of amalgam is permitted, it should still be offered as a treatment option for patients – where appropriate
- A common pitfall in practices promoting themselves as amalgam- or mercury-free is that the information and options provided to patients can sometimes present a very one-sided picture
- Present the range of available options to the patient in an objective and balanced fashion. If not explained in this way, the validity of any consent obtained may be compromised.

For the most part, new dental materials represent a refinement or improvement of an existing class of material. Wholly new innovations arise less frequently, but often revolutionise the way in which care is delivered.

Novel materials usually undergo a period of development and evolution as was seen with the composite materials developed for the restoration of posterior teeth. There is an increasing emphasis on the importance of evidence-based practice, although in biomaterials technology, new products are often superseded by even newer versions before any long-term *in vitro* studies are published. This presents a dilemma for clinicians who are keen to embrace new innovations but anxious to do so responsibly. At the other end of the spectrum, are those clinicians who have found a material whose properties and handling characteristics particularly suit them. This can sometimes lead to an over-reliance on one particular type of material, and reluctance to consider change. In the process, patients might be denied the benefits of any improved characteristics inherent in the newer material.

Appropriate use

The manufacturers of glass-ionomer cements (including resin-modified versions) do not normally recommend the use of these materials in load-bearing Class I or Class II restorations in permanent teeth. However, it is not uncommon to see these materials used in unsuitable situations that have the potential to generate complaints or even legal, contractual and regulatory challenges.

Some clinicians become so enthralled by a particular innovation or material that they seek to use it wherever possible; for example, all-ceramic restorations using CAD-CAM technology. In these circumstances, the treatment options presented to the patient may well be heavily influenced by the operator's preference or perhaps even commercial motives, sometimes at the expense of other (and often cheaper) options. The need to present patients with a balanced explanation of all the viable options remains constant, even where new and exciting alternatives come along.

Augmentation

The use of implants has increased exponentially over recent years (see page 41). Most of the failures can be traced back to clinical shortcomings but some are related to the materials themselves. The range of clinical situations in which implants can successfully be used have been greatly expanded by the use of bone augmentation techniques. However, it is important to realise that the use of certain alloplastic graft materials (particularly those derived from other animal species) may present difficulties for some patients due to ethical, religious and sometimes legal concerns. The same applies to the use of bone material obtained from cadavers and especially where this is purchased on the internet and then imported without the necessary licenses.

Poor patient tolerance can also result from an allergic response. Although implant systems are normally made from high-purity titanium – one of the most biocompatible materials known – the milling devices used in implant manufacture may contain nickel, and manufacturers are sometimes unable to guarantee the surfaces are not contaminated by trace amounts of this potentially allergenic material.

Conclusion

Further significant developments in biomaterials are likely to continue, but clinicians should not allow a personal or commercial bias to displace the need for a well-considered choice of the materials used, nor the basic principle of providing the patient with the full range of available options when planning their treatment rather than steering them too forcibly towards one particular alternative.

Changing the patient's self-image

Preventive dentistry 44
Multi-disciplinary cases 45
The only thing that is constant in life is change 46

Preventive dentistry

The promotion of healthy lifestyles lies at the heart of any healthcare profession, but poor communication can be a problem. The answer lies in the careful nurturing of an appropriate approach

Promotional platforms for health promotion

- Print
- Downloadable documents
- Website
- Video
- Email (ensure you have the patient's permission first).

A healthy world

The Ottawa Charter[1] – and many other international declarations on health – highlight the importance of health promotion and have resulted in the adoption and formulation of public policy around the world geared towards prevention of chronic disease. The WHO Global Oral Health Programme (ORH) reflects many of these goals and challenges going forward towards 2020 in reorienting public policies in oral health promotion and oral disease prevention.

Whilst the direction of travel in public policy may be clear, it is often less obvious how these goals translate into action at a local level – and in what way the need to promote healthy lifestyles impacts upon our patient interactions.

Many complaints and claims have poor communications at the heart of the problem. Communication is complicated and challenging because very often both the patient and the healthcare provider are uncertain of their respective roles and responsibilities. All too often dental clinicians deliver care and advice without seeing any noticeable behavioural change adopted by the patient subsequently.

Regrettably, when things do go wrong, the patient often blames the clinician for the consequences. As diseases such as periodontitis most commonly develop over a number of years, this can end up being very complicated to defend, particularly when a number of clinicians have been involved in providing care.

The root of the problem may lie in the type of patient/clinician relationship that we create. Many clinicians still take an "informative" approach to providing patients with advice on disease and, consequently, a menu of options to deal with the problem[2]. Unfortunately, this approach fails to appreciate the patient's view and asks them only to make a decision. Sometimes, this decision can be the wrong one for the patient and this creates scope for a future complaint or claim.

Perfect model?

We need to consider alternative approaches, one of which has been described as the "interpretive" model, where the clinician tries to "elucidate the patient values" and provide a solution based upon understanding of those values[3]. Increasing numbers of patients derive much of their health information online (see pages 12–16) and, because the quality of that advice varies widely – depending on the source from which it derives – part of our role must be to help them to filter, interpret and make effective use of this information. Some clinicians feel intimidated and even offended by patients asking questions or refusing blindly to accept what they are told, and follow instructions that they are given. It may be necessary to go further than giving simple advice. As uncomfortable as these occasions might be, we may need to gently challenge the patient's beliefs (the so-called "deliberative" model[4]), especially when these are clearly contrary to the prevailing scientific evidence eg: those patients who refuse to allow the use of fluoride topical gel or toothpaste, or who believe that regular drinks of fruit juice during the day can only be good for a young child. We are abdicating our role as healthcare professionals if we do not have these conversations, but ultimately it is for the patient to decide.

Motivate

In busy practices, the opportunity to educate and motivate on a face-to-face basis may be restricted to a precious few minutes every year. It is important these patient/clinician interactions make optimal use of the time available to discover what image the patients have of themselves – how much responsibility do they take for their own health? There is a need for the dental team to emphasise that the provision of treatment alone can only ever have limited impact on an underlying oral health problem – doing and saying things that make the patient dependent upon us is not really helping the patient. Whilst the dentist and the clinical team can often be the catalyst for change, ultimately it is the patient who must take charge and realise that this is their problem. Emphasising the patient's role should also empower them to change[5].

[1] Charter adopted at the International Conference on Health Promotion, November 17-21, 1986 Ottawa, Canada

[2] For further reading please refer to Emanuel, Ezekiel J., and Linda L. Emanuel. 1992. Four models of the physician–patient relationship. Journal of the American Medical Association 267.16: 2221–2226

[3] Ibid

[4] Ibid

[5] For further reading please refer to Haslam, David. 2012. Health Services Journal, available on the worldwide web at http://www.hsj.co.uk/resource-centre/best-practice/public-health-resources/getting-patients-to-take-responsibility-for-their-own-health/5044859.article#.VMuPP5XyFhE 31 May, 2012

Multi-disciplinary cases

Dental situations that need the input of two or more clinicians are increasingly common: good communication is essential

It takes two...

- Was just one of the clinicians responsible for the less than ideal outcome or was the overall joint treatment-plan flawed?
- Who took responsibility for explaining the risks and benefits of the treatment to the patient?
- Is this clinician solely responsible if the patient's expectations weren't met?
- If the problem arose during the treatment, who was responsible for identifying it and putting it right?

Be mindful

Multidisciplinary
+
Misunderstanding
+
Miscommunication
=
Mistakes

Many clinicians will have experienced a multidisciplinary case – a common one is when patients have missing upper lateral incisors. In this type of case, most clinicians would agree the initial role of the general dental practitioner (GDP) is to ensure the patient's overall oral health is stable – and to refer the patient to an orthodontist at the appropriate age.

Almost immediately, further potential problems may be encountered:

- Should the GDP explain what is involved with orthodontics, so that a disinterested patient doesn't have a wasted visit - or is this the orthodontist's role?
- If oral hygiene is poor, should the GDP refer the patient anyway so the orthodontist can explain what treatment is available?
- Or, should the GDP wait until the patient can brush their teeth adequately to avoid the patient being turned away by the orthodontist?
- If the orthodontist accepts the patient for treatment, is it reasonable for him/her to assume that the GDP is taking care of the patient's oral health and hygiene?

If the orthodontist decides the most appropriate treatment plan is the creation of space in order that the laterals can be replaced, then there is a potential for misunderstanding between the clinicians or between a clinician and the patient, which may subsequently lead to a complaint.

In particular, the following questions need to be answered:

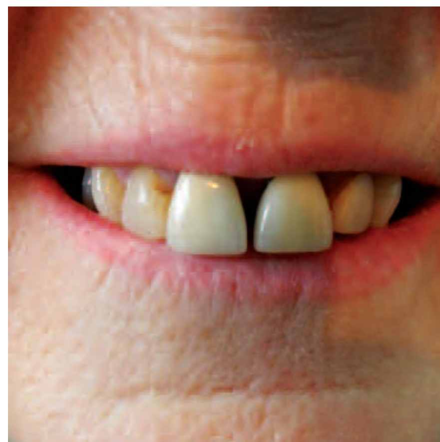
- Is the GDP willing to provide the replacements for the laterals?
- What type of replacement?
- At what cost?
- Have the risks and benefits of the proposed replacements been discussed with the patient and recorded?
- Where and by whom?

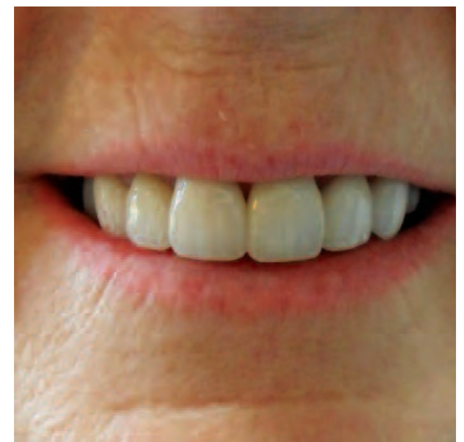
Without such clarification, a GDP may be presented with a patient who has had their orthodontic brackets debonded and who is now expecting implants or adhesive bridges to be fitted - perhaps for free, assuming the cost was included in that of the orthodontics and all part of the same course of treatment.

Alternatively, an orthodontist may need to close space because the patient was unaware they would have to cover the cost of replacements for the laterals and are unwilling to do so.

Orthodontic treatment also presents a particular dento-legal challenge in a multidisciplinary case because of the length of treatment. Patients are often confused as to who is responsible for what and unaware that they should be attending their GDP as well as the orthodontist.

If a dental problem (eg. caries) arises during treatment – and the orthodontist fails to identify this – the patient may have reason to complain. The orthodontist may not be willing or able to treat the caries but they still have the same duty of care as any other dentist to identify it and have appropriate discussions with the patient and the referring dentist. Similarly, a GDP may be criticised for not spotting a significant problem with a patient's orthodontic appliance. All the clinicians involved in a multidisciplinary treatment need to be mindful of their overall duty of care to the patient. An assumption that the other clinician was dealing with the problem will be viewed as a very poor defence.





The only thing that is constant in life is change

In dentistry, as in any profession, there is a world of difference between early and late adopters but adapting to change is necessary and some of us take longer than others. So, for the reluctant ones, how best to cross that chasm?

The words in the title come from the Greek philosopher, Heraclitus. Developing our own philosophy that allows us to accommodate change is an invaluable life skill in a world that is changing at a faster pace than ever before. Some people are so good at it, they lead the way and inspire others in the process. A few resist the opportunity to evolve and grudgingly stick to their old and familiar method of doing things. Age and infirmity can inhibit the ability to adapt to change, but fear or excessive caution can also play a part, as can a reluctance to appear foolish in a strange new environment.

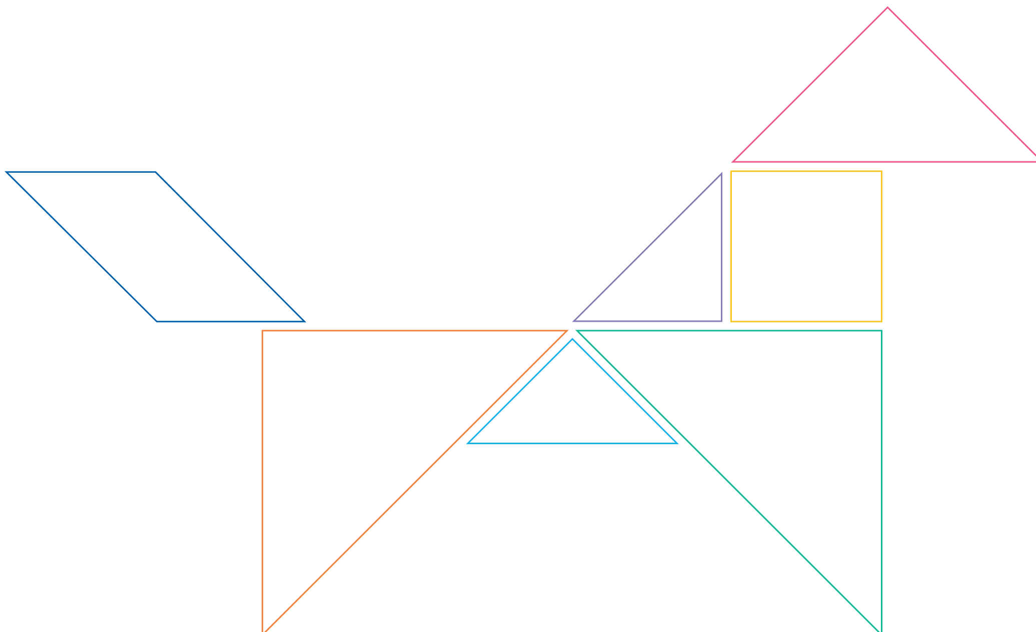
If you are too close to any situation that generates fear, you can sometimes lose the ability to accurately assess the true nature of the problem. This phenomenon has a name. It's called propinquity. Gaining some distance – and developing better control – can be achieved by breaking down the issue into its component parts. Reframing the situation in this way introduces a sense of proportion and facilitates a more positive attitude.

There is nothing new in the need to adopt changes – but the interconnected 24-hour world in which we live, invites us to engage with transformations a lot more frequently than in the past. Healthcare workers are exposed to higher levels of change than many others in society and this can create stress that impacts on their professional decision-making and patient interactions.

Complexities

Dental Protection recognises that the complexity of life can sometimes block the desire to change. Our team of dento-legal advisers can help point you in the right direction if there is something inhibiting a particular "change" you would like to make in your professional life – particularly if the situation is currently having a negative effect on your dentistry.

Remember many others have faced similar problems in the past. You are welcome to contact Dental Protection to discuss your own professional problems with one of our many dento-legal advisers. The contact details of your nearest office can be found at the back of this publication.



About your membership

Essential facts 48–49
Understanding the way in which indemnity is provided 49
Subscriptions and Membership benefits 49–50
Getting the best out of your membership 52–56
How we can help 56–57

Membership

This section of our Annual Review provides really important information about your membership, what you can expect from us and what we in turn expect of you. Please take the time to familiarise yourself with it before you need our assistance, because we want you to understand how to get maximum benefit from your membership

Essential facts

About Dental Protection

Dental Protection Limited (DPL) is a member of The Medical Protection Society Limited (MPS) group of companies. Dental health professionals can apply to become dental members of MPS, served by DPL, with access to all the benefits of membership which are set out in MPS's Memorandum and Articles of Association. "Dental Protection" is a trading name of both DPL and MPS, and is used in this section to refer to the function of MPS that supports the dental members of MPS (such members also being referred to in this section as "Dental Protection members").

MPS is not an insurance company, but a mutual (not for profit) organisation which exists to serve and protect its members and to safeguard their professional reputation, interests and integrity. MPS is the world's largest professional indemnity organisation for doctors, dentists and other healthcare workers. All the benefits of membership of MPS are discretionary (refer to "understanding the indemnity product" below).

DPL exists to advise MPS on the unique interests and concerns of dental health professionals, and to provide a service which is designed to meet their specific needs.

As a mutual membership organisation, the subscriptions paid by the membership over the years have created a strong mutual fund owned by the members themselves. We do not exist to make profits, and we have no commercial (profit-making) partners seeking profits, or shareholders seeking dividends out of the subscriptions paid by members. The mutual fund is held for members, and one of the responsibilities of the MPS Board of Directors (MPS Council), and the Board of DPL, is to ensure that this fund is used only for the specific purposes for which members have paid their subscriptions.

Governance

DPL is governed by its own Board of Directors, exercising powers delegated by MPS Council. The Board of DPL are all registered dentists except for the two ex-officio members nominated by MPS Council, namely the Chief Executive of MPS and the Chair of MPS Council. Similarly the Chair of the Board of DPL is an ex-officio member of MPS Council.

DPL is operated by and for dentists, and exists solely to serve and protect the interests of dental members of MPS. It advises MPS Council on all matters affecting the interests of the dental members of MPS throughout the world and provides, on behalf of MPS, membership benefits and services to dental members. Because MPS is owned by its members, the dental members of MPS also share in that collective ownership.

Focus

MPS has been protecting and supporting doctors, dentists and other healthcare professionals for more than 120 years and dentists have been members from the very beginning. The purpose of establishing Dental Protection was to ensure that the founding "doctor for doctor" principles which had been at the heart of MPS's success over the years were extended to the dental profession.

Dental Protection members thereby enjoy the best of both worlds: the dedicated function of Dental Protection means that we can focus upon dental issues and needs specific to the dental team, whilst benefiting from 120 years' worth of wider strength and experience.

Specialists

The provision of professional indemnity and risk management advice and services for dentists and other members of the dental team is necessarily different to that for other branches of medicine. Dentists and other dental health professionals understand the fact that dental practice is not the same as medical practice. We carry out different procedures, in different circumstances, and many of the problems we encounter are quite unlike those in medicine. Reflecting this fact, the specifics and detail of the service to and for dentists will need to be quite different in many ways to that for medical practitioners, with different needs and priorities, and different clinical settings and situations to understand.

Kevin J Lewis

Susan Willatt

David J Croser

John P Tiernan

Sue Boynton

James Foster

Stephen Henderson

Helen Kaney

Jane Merivale

Alasdair McKelvie

Brian Westbury

Dental Protection exclusively looks after members of the dental profession and all our energy can therefore be focused on serving and protecting their interests. We understand the needs of the dental team because all Dental Protection team members have always been an integral part of the profession we serve.

We believe that dental professional indemnity should remain in the hands of people who really understand the dental profession, and not treated as a convenient add-on product or additional revenue stream for commercial insurance companies and other organisations whose primary focus lies elsewhere.

Understanding the way in which indemnity is provided

Discretion

MPS is a discretionary mutual organisation. This means that instead of a tightly worded contract (policy) of insurance, defining what will and will not be covered and containing a long list of terms, conditions and exclusion clauses, there is instead the right to request discretionary assistance in accordance with the MPS Memorandum and Articles of Association (see note* page 50).

This discretionary model allows us to adopt a flexible and constructive approach to individual cases (especially ones which are particularly unusual, complex or challenging) and it enables us to assist members in a wide range of situations where most contractual insurance policies would almost certainly exclude cover.

We have an obligation to use discretion fairly, responsibly and in the interests of members. Discretion must never be used arbitrarily or with improper motives. Dental Protection is proud of the responsible use of this discretion in many thousands of cases, often extending the support given to members when they needed it most.

We have a long history of pursuing important points of principle on behalf of members, and a proud record of successful legal challenges in courts of law and other high profile arenas all over the world. All this is made possible by the existence of our discretionary powers, coupled with an unwavering commitment to purpose, and a determination to preserve the mutual principles upon which MPS was founded more than 120 years ago.

Occurrence-based indemnity

We recommend and generally* provide occurrence-based indemnity to members. This means that a member's entitlement to seek assistance is unaffected by the passage of time between the date of treatment and the date of any subsequent claim arising from it. The defining requirement is that the member had paid the correct subscription, in an appropriate membership category, at the time when the treatment was provided or the incident occurred. This is important, since a feature of many dental claims is the long delay between incident and claim.

Subscriptions and Membership benefits

Subscriptions

The subscriptions charged to Dental Protection members are set on the best available actuarial advice, on the basis of our dental case and claims experience in each individual part of the world.

We are a not-for-profit discretionary mutual organisation, so we do not set subscriptions with the intention of making a profit, but simply to provide prudently for the present and future needs of our members. It would be irresponsible of us to do otherwise. We have no commercial (profit-making) partners, so there is no profit for any such partner included within the subscription you pay to us.

Secondly, because we are not an insurance company, your subscription is for membership of a mutually-owned organisation – one that you have a personal stake in – and does not represent an insurance premium. Consequently, there is no insurance premium tax (stamp duty) contained within your subscription*.

Alan M Cohen

Andrew Collier

Brian D Edlin

Hugh Harvie

Raj Rattan

Michael C Clarke

Janet Barnes

Charlotte Boyd

Thirdly, as a mutual organisation we aim to be fair and equitable when setting subscriptions for different groups of our members, and with this in mind a range of membership grades (categories) are offered in various countries. Members who are considered to represent a particularly adverse risk for the mutual fund, for any reason, may be asked to pay a higher level of subscription and their continued membership may be subject to conditions such as participation in educational or other activities designed to reduce their risk. In this way we try to minimise the extent to which such members are effectively subsidised by the membership as a whole.

Note*

In a very small number of international jurisdictions, there is a legal requirement to cover certain dento-legal risks by means of a contract of insurance. In some instances, the local legislation or regulatory environment makes it difficult, or perhaps not commercially feasible, for us to offer occurrence-based indemnity, as we would prefer to do for the reasons stated above. Where this is the case, members will be advised locally of the arrangements that have been made to protect their interests, whilst complying with the local legislation and regulatory requirements. In these jurisdictions, insurance premium tax (stamp duty), where applicable, needs to be charged on any insurance premium paid to the provider of the insurance.

Membership benefits

A wide range of benefits is available to Dental Protection members, under the provisions of the Memorandum and Articles of Association (copies of which are available in PDF format on the Dental Protection website www.dentalprotection.org)

In a small number of international jurisdictions where there is a legal requirement for certain circumstances and risks to be covered by a contract of insurance, rather than by discretionary assistance, some of the benefits that would otherwise apply may be the subject of a contract of insurance from a third party. Members for whom this applies will be notified separately of the details. In such situations, discretionary assistance from us may be limited by law to those circumstances which are not covered by the relevant local legislation.

Important reminders

Payment of subscriptions

Each member has a responsibility to ensure prompt payment of their annual subscription when it falls due, and also to advise us of any change in bank/credit card details where payment is being made in this way. Members are also required to advise us promptly of any material changes in their practising circumstances. The notification of such change should be made to Dental Protection when it first becomes apparent to the member that the change in situation has occurred, is imminent or is likely to occur before the end of the membership year. This is particularly important when a member is moving to a country or a working arrangement where a different rate of subscription may apply.

It remains a member's personal responsibility to ensure that:

- Subscriptions are paid when due, whether or not any reminders are sent or received. Prompt payment helps us to make better use of our members' subscriptions by reducing administration costs. Members whose subscriptions are overdue may lose their entitlement to the benefits of membership, and their membership may be terminated. Members are therefore strongly advised to check with their bank or financial services provider to ensure that any payments due to be made have been correctly processed at the due time.

- The correct subscription is being paid at all times, in a membership category that properly reflects the geographical location, the full extent of the work done/position held and any other relevant factors. Members who are claiming a reduced subscription rate in one of our concessionary categories should also check that their current circumstances still justify this concessionary grade, and be prepared to demonstrate that this is so. Membership categories and the qualifying criteria are regularly reviewed and they do change from time to time – members are strongly advised to check at every renewal date that the category and rate that they are paying is still the correct one. Members should certainly not expect that they will be allowed to correct retrospectively a previously under-paid subscription rate, perhaps after they have become aware of the potential for a claim or complaint relating to the period in question. In such cases the right to any assistance with such cases is likely to be lost.

Caroline Chapman

Leonard T D'Cruz

Julia Densem

Martin Foster

Richard Hartley

David Hartoch

Joseph Ingham

Ravi Rattan

An invitation from Dental Protection to a member to renew their membership in the same category as applied in the previous year(s) does not transfer any responsibility as to its accuracy to Dental Protection. It is every member's personal responsibility to make any necessary enquiries of us to ensure that they are in a correct category and paying a correct subscription based on all relevant facts, at all times.

Your right to apply for assistance may be prejudiced if you are paying, or had previously been paying, an insufficient subscription at the relevant time(s).

Contact details

Members are required, as a condition of their membership, to supply a current address or other reliable means of contacting them, and to advise us promptly of any change in these details. This enables membership reminders and other important correspondence to be received and acted upon promptly, thereby avoiding a situation where a member overlooks the renewal of his or her membership, and loses the right to membership benefits in relation to matters that may not come to light until months or years later.

Members without a permanent address should ideally register with us to receive membership communications electronically (see below), or alternatively provide a reliable forwarding address. In the latter case it is preferable that this address is in the country where you are practising, to avoid any potential confusion over the appropriate subscription rates, since different rates apply in different countries. The absence of a current contact address could mean that you might not receive your subscription renewal documentation or other important communications from us.

We may, for example, become aware of a claim against you arising from a former working address, and the need for us to be able to contact you promptly in such situations will be self-evident. We will not be able to provide you with assistance if we have not received and are unable to obtain instructions from you, and in any event we are unlikely to accept responsibility for costs incurred as a result of a member's failure to provide us with a reliable, current address or email contact details.

Registering your email address

Members should make the most of their membership by registering their current email address with us. In addition to statutory communications, other important updates and information can be sent. It is also possible for qualifying members in the UK and Ireland to register proxy votes at the Annual General Meeting and other statutory meetings via Member Services Online. Visit www.dentalprotection.org **and follow the link on the homepage**.

Membership queries

Dedicated telephone numbers provide direct access to the Member Operations Service Centre, which is based in Leeds, UK. This team administers the initial application process and the annual renewal of direct members in all categories and it is trained and equipped to handle a large range of membership enquiries by telephone, letter or email. Special arrangements apply for scheme members (see explanation below), which vary from one country to another.

Schemes of co-operation and direct membership

Subscriptions are paid either through schemes of co-operation or by direct membership.

Schemes of co-operation

A 'scheme of co-operation' is a formal relationship between Dental Protection and a local (or national) representative – often, a dental association or similar body. In most cases the scheme administrator collects the subscriptions locally, on behalf of Dental Protection, and carries out various other administrative functions, which might include local assistance with complaints handling, providing ethical advice or (in some instances) case management in liaison with Dental Protection. In other cases the scheme partner provides local advice to, or on behalf of, Dental Protection and/or provides services and benefits that Dental Protection would otherwise be providing. This results in a cost saving which can be reflected in lower subscription rates for their scheme members.

Lynn Rees

Susie Sanderson

Alan JS Seaton

Phil Shaw

Yvonne Shaw

Terry Simpson

Barry Tiernan

Stephanie Twidale

Direct membership

Direct membership means that the membership contacts and administration take place directly between Dental Protection and the member, with no third party (such as a scheme of co-operation) intervening. This arrangement is available in the UK, Ireland and many other countries for those members who prefer this relationship. Because of the additional costs of administering direct membership, when compared to membership through an international scheme of co-operation, the direct subscription will usually be greater than that which could be obtained through the local scheme of co-operation, in countries where such an arrangement exists.

Members who practise in more than one country/jurisdiction or who relocate (temporarily or permanently) from one country to another should notify our Member Operations Service Centre or the local scheme administrator promptly and provide full details. This also applies where members are working for very short periods in another country, perhaps in connection with a teaching commitment (members should be aware that in some countries it is necessary to apply for registration and/or work permits even to provide a single lecture). Subscription rates vary across the world and the correct subscription must be paid to ensure that the full benefits of membership remain available to you in each country where you work.

Members who subscribe to us directly ("direct members" – see above) will be advised of any rate changes and will be sent their individual renewal forms direct from our Membership Operations Services Centre in Leeds, UK. Members who subscribe through schemes of co-operation or local Dental Protection offices including Australia (some States only), Hong Kong, Kenya, Malaysia, New Zealand, Singapore, South Africa, some parts of the Caribbean and elsewhere will be notified of changes in subscription rates by the relevant Dental Protection office or scheme administrator, to whom any subscription query should be addressed.

Contact our Member Operations Service Centre or your local scheme administrator for information about current membership categories applicable to your own location. Not all of the categories of membership are available in every international jurisdiction, so there may not be a directly comparable equivalent when you move between countries. In general the range of options will tend to be greater in those countries where we have the greatest number of members and/or where other factors introduce additional complexity.

Lapses in membership

Anyone whose membership lapses may need to re-apply for membership in the same way as a new applicant, and the underwriting process may need to take into consideration any previous lapse(s) in membership.

Getting the best out of your membership
(and how requests for assistance are generally approached)

Records

Always make and keep full, accurate and contemporaneous notes. Whether held in hard copy or electronic form, they should be legible, intelligible, objective and written in the knowledge that they might, one day, be referred to in a court of law or similar investigatory forum.

Under no circumstances should the original contemporaneous records (whether held electronically, or in paper form) be tampered with after a problem has arisen; such acts of dishonesty can have serious professional consequences. When writing any records, which include correspondence with or about the patient, you should be mindful of the fact that in many countries, patients have a legal right of access to copies of their records on request.

Records should be safely preserved for an appropriate number of years after any episode of treatment. This timescale varies according to the laws of each individual country. In general, records (including x-rays, models, etc.) remain the property of the clinician (or practice owner) and originals should not be released to patients or other third parties. In both these respects we would be happy to give appropriate local guidance upon request.

Michael L Butterworth

Nancy Boodhoo

Geoff Baggaley

Jasdeep Baydal

Amanda Biddle

Elaine Cook

Raj Dhaliwal

Caroline Dodd

Vicarious liability

If an employee commits a negligent act or omission whilst acting in the course of their employment, the employer can be held to be vicariously liable for any resulting claim. So also can a dentist who, even if not the actual employer, is directing, actively controlling or supervising the work of, for example, a dental nurse. This can apply even in situations where the negligent act was expressly forbidden by the employer, or where the omission represented a failure to follow reasonable instructions given to the employee by the employer.

However, there is an implied term in most contracts of employment that employees will exercise reasonable skill and care in the performance of their duties. Where an employee's wilful act or omission, gross misconduct or negligence results in a claim against the employer, the employer is generally entitled to seek "contribution and indemnity" from the employee, which may take the form of demanding a financial contribution from the employee towards the expenditure (including legal costs) incurred by the employer.

Partners are jointly and severally liable in legal actions brought against the partnership and it is essential that each partner and every assistant is a member of a recognised protection or defence organisation, and/or is appropriately and adequately indemnified/insured.

Before engaging any full-time or part-time employee or locum, you are advised to satisfy yourself as to their credentials, and seek evidence of registration (if applicable) and professional indemnity, as well as any other statutory requirement (for example, a work permit, if applicable). The currency of these documents should be checked annually, and copies retained indefinitely, because there are many instances in which you would need to be able to produce them, perhaps many years after the end of the period of time to which they relate.

It is important that members should understand that our subscriptions for each individual member are calculated on the basis of the risk represented by a single member. In the interests of fairness across the membership as a whole, members should therefore not expect to be indemnified for the acts and omissions of any other dentists, on the strength of a single annual subscription being paid by one member (such as the practice owner). This applies equally whether the other dentists are partners, employed by the practice, locums or deputies, or self-employed independent contractors who might be considered to be in a "de facto" employment relationship with you.

Members need to be mindful that they may therefore be personally exposed to these risks. However, in wholly exceptional circumstances and on rare occasions we may use our discretion to depart from following the general principle described above, where a member can demonstrate to the satisfaction of MPS that they have taken all reasonable steps to mitigate their exposure to such claims. Members can look to us for assistance in the usual way if through no fault of their own, having taken all reasonable precautions and having followed the advice below, they find themselves drawn into a claim which alleges their vicarious liability.

The steps that might sensibly be taken vary from one country to another because of differences in local law and its application but as a minimum the steps below should be taken by practice owners or others with potential vicarious liability:

a Ensure that all members of the dental team are operating within the limits of their competence and/or legally permitted scope of practice.

b Practice owners should ensure that they have a written agreement with both the registered and non-registered personnel that they employ, and any other registered health professionals with whom they work.

c Make it a condition of employment or a term of any other contractual relationship that adequate and appropriate professional indemnity should be maintained by every registered healthcare professional, at all times.

d Ensure whenever possible that the person's professional indemnity is occurrence-based (see page 49) because this helps to avoid some of the potential exposure.

Ian Gordon

Jane Griffiths

Sarah Harford

Lesley Harrison

Russell Heathcote-Curtis

Peter Hodgkinson

Jill Jagger

John Kocierz

e If the person's indemnity takes the form of "claims-made" insurance, this wherever possible should include "run-off cover" (an extended reporting period) in perpetuity, without this being dependent upon payment of any further premium. A copy of any such insurance policy should be obtained to determine its terms, conditions, limits and exclusions. Members should seek appropriate advice to satisfy themselves as to the adequacy of any such insurance policy and to identify any residual risks to which they might personally become exposed.

f Insist on sight of documentation to confirm that professional indemnity has been renewed annually and/or any agreed payments by instalments have been honoured. Keep copies of any documentation to demonstrate that these crucial checks have taken place and the necessary indemnity was in place at all times.

g The employer should do everything possible to reduce the likelihood of complaints and claims being made either against themselves, or against the person in respect of whom they might be held to be vicariously liable.

Co-operation

Members are required (under 40(6) of the Articles of Association) to co-operate fully with us, and to accept and follow our considered advice and guidance when we are assisting with a case on their behalf. Members should provide information promptly when asked to do so, should reply to correspondence and respond in timely fashion to any other forms of contact from us or on our behalf, and should make themselves available for any meetings that may be necessary in the proper management of the case. Assistance may be withdrawn at any time if this co-operation is not readily forthcoming, and the member concerned will generally be held responsible for any costs incurred unnecessarily as a result of his/her lack of co-operation. Any financial contribution sought from a member on this basis, and which remains unpaid, is considered as a liability under the terms of the Memorandum and Articles of Association, and until such time as it is paid, the member ceases to be entitled to the benefits of membership.

Members are encouraged to tell us about any personal problems or circumstances that are preventing their full co-operation, and we will always do our best to respond with sensitivity and understanding, while also being mindful of our responsibilities to the membership as a whole and the proper and responsible use of the subscriptions that members pay to us. It is not acceptable, however, for individual members simply to ignore communications from us, or any attempts we make to contact them, nor is it fair to waste the time and resources of Dental Protection, thereby compromising and undermining the service we are able to provide to other members. In such situations, assistance may be withdrawn and members should not assume that we would continue to represent them in the absence of their full co-operation, including their willingness to attend meetings, case conferences and hearings.

It is our policy to keep members fully informed and involved in cases concerning them, but ultimately the management and conduct of a case remains at our discretion, reflecting the best legal and other expert advice we obtain. This principle is important if the broader membership is to be properly protected against costly and perhaps misguided legal or other challenges that might be favoured by an individual member, contrary to our considered assessment of a specific case.

However, where a member is not responding to our communications, we may take decisions on their behalf without further reference to them, in the proper and timely management of a case and in order to avoid additional costs being incurred unnecessarily.

Contributions to settlement

When approaching the management of cases, we adopt the general principle that it would be inappropriate for an individual member to "profit" from the provision of unsatisfactory treatment, while the membership as a whole is left to meet the resulting costs. In a mutual organisation such as ours, this principle is felt to be particularly important, especially in cases where significant fees have been received by the member concerned, or where the same member has been involved on more than one occasion.

With this principle in mind, we may ask for the return of the "profit" element of fees received for the dental treatment in question. Although not all "profit" in its broadly accepted sense, this contribution to the overall settlement, made by the dentist(s) concerned, seems to be the most equitable way of ensuring a proper distribution of this aspect of the costs amongst all members. The extent of any such "profit" contribution requested will inevitably vary according to the circumstances of each individual case.

Neena Manek

Adrian Millen

Bernice McLaughlin

David Monaghan

Michael Morris

Nikolaus Palmer

Shiv Pabary

Shreeti Patel

Where a member has acted contrary to the advice given by Dental Protection (or its local representatives) either generally – as set out in this publication – or in the specific circumstances of a case, a member may be asked to contribute an appropriate amount towards the total costs of conducting the case.

The extent of any such contribution would normally be equivalent to any costs incurred over and above those which might reasonably have been expected, had the member sought and/or followed advice given by us, or on our behalf.

Any contribution sought from a member on this basis, and which remains unpaid, is considered as a liability to MPS under the terms of the Memorandum and Articles of Association, and until such time as it is paid, the member ceases to be entitled to the benefits of membership.

Other circumstances in which a member may be expected to make a personal financial contribution include:

1. Cases that include elements that fall outside our normal scope of assistance (for example, non-professional matters or matters relating to personal conduct), but where it is not practicable to separate the conduct of the case into those parts that we should, and should not assist with.

2. Cases which include both some aspects with which the member is entitled to assistance, but also some events which occurred outside a period of MPS membership, or during a period where the member was in an incorrect category, therefore paying insufficient subscriptions.

3. Cases where additional costs are incurred by us as a result of a member's lack of communication and co-operation, or provision of incomplete/misleading information which is later corrected or withdrawn. This would in most cases include situations where allegations or facts are initially denied but later admitted.

4. Situations where a member wishes to conduct a case in a way which is contrary to that which we believe to be appropriate, proportionate and/or in the member's best interests. In this situation an alternative approach might be to invite the member to conduct the case on his/her own authority and instructions and at his/her own expense, leaving open the option for the member to ask us, upon conclusion of the case, for a retrospective and discretionary contribution to the costs incurred.

5. Where a member insists on using solicitors of their own choosing, we would be unlikely to make any contribution to the costs incured.

Where contributions are required from members in situations such as those described above, part or all of the sums requested may need to be paid before further legal costs are incurred by us on the member's behalf.

Business/financial matters

In general, we would not normally assist with matters which are considered to be purely, or largely of a business/commercial/financial nature. Debt collection or enforcement, or disputes over money claimed and/or received by a member, owed to or by a member, or levels of remuneration, are typical examples.

Disputes or challenges in relation to employment or business contracts entered into by a member would normally be viewed as a business or personal matter, even if the activity to which the contract relates is connected in some way with the practise of dentistry. An example of this might be a claim for payment for professional services, which is likely to be viewed as being distinct from the actual delivery of the professional services themselves. Similarly a member might be pursued for civil damages for having failed to honour the terms of a private contract that they had entered into, and this would normally be considered as a business matter outside the proper scope of our assistance. This would normally be the case, even if the activity to which the contract relates is connected in some way with the practise of dentistry.

Fines, awards of punitive/aggravated damages, payments of damages or costs resulting from employment/business (as opposed to professional) matters and requirements to repay money received from patients or third parties (for example, health funds, state payment agencies, insurers, etc.), remain a member's personal responsibility at all times, and we would not normally pay or reimburse any such outlay on behalf of a member.

Andrew Paterson

Sudhir Radia

Simrit Ryatt

Helen Sayer

Bernard Swithern

Lesley Taylor

Martin Valt

Claire Walsh

Personal versus professional conduct

Some cases raise fundamental questions of whether the conduct about which a member faces a complaint or legal action arose directly out of the practise of dentistry or out of personal conduct which was not directly related to the practise of dentistry.

The acts may be only loosely related to the practise of dentistry (for example, by virtue of having been committed at the work/practice premises, or because they happened to involve an employee or working colleague). Each case is considered very carefully on its individual merits, but in general, requests for assistance with personal matters when any connection with the practise of dentistry is either not established at all, or at best is tenuous or indirect, are outside the scope of assistance.

Where allegations relate to acts or events wholly unrelated to dentistry, assistance is very unlikely to be provided, because this is not a purpose for which the subscription was collected.

Charges relating to driving whilst under the influence of alcohol or other substances, even if the journey was in connection with the treatment of a patient, is an example of a situation where assistance would not normally be considered to fall within Dental Protection's proper scope of assistance. Acts of fraud, dishonesty/deception or indecency which happen to take place in connection with the business or practise of dentistry would likewise be outside the scope of assistance.

Situations might arise where a professional regulator/registration body wishes to investigate acts which have been the subject of a criminal conviction of a registered dental health professional. A criminal act cannot reasonably be considered to be the normal practise of dentistry, and nor is it possible to "go behind" the fact of the conviction. Consequently it is highly unlikely that further assistance would be given in any claim resulting from a criminal act, subsequent to the conviction.

Similarly, members would not normally be assisted with any regulatory investigation arising as a result of an event which was from the outset wholly a matter of personal conduct on the part of the member concerned. Personal conduct can take many forms, but by way of illustration, a member may decide to claim fees from a third party in circumstances where he/she could or should have been aware that the fee claim was inappropriate. That decision and that action to claim the fees would normally be viewed as personal conduct even if the claim happened to relate in some way to the treatment of a patient. Similarly, a member may knowingly carry out treatment contrary to undertakings given, or conditions imposed on his/her registration. Taking the decision to undertake that treatment, in those circumstances and in full knowledge of the potential consequences, would normally be viewed as personal conduct; quite separate from any professional issues arising from the treatment itself.

How we can help

24 Hour emergency helpline

T +44 (0)20 7399 1400

F +44 (0)20 7399 1401

T 0800 561 1010

(Freephone accessible within UK only)

Other ways of contacting us

Please refer to the local contact details on pages 60–61.

Don't panic – help is at hand

One of the many advantages of being a member of a specialist organisation such as Dental Protection is that you are able to discuss your problems and concerns with experienced dental colleagues who can empathise with and understand the situation you are facing. Members are also reminded of the availability of the free global counselling service, details of which are provided on the website and encouraged to take advantage of this service if they feel the need to do so.

Alison Williams

Martin Woodhead

Jane Woodington

Dr David Evans

Dr Annalene Weston

Dr George Lazaridis

Dr Mike Rutherford

Dr Ralph Neller

Vicki Biddle

Requests for assistance

Immediately on becoming aware of any claim or the likelihood of any claim, or the need for advice on any aspect of dentistry which could put your professional integrity at risk, you are asked to notify us as soon as possible and seek our advice. If you are served through a scheme of co-operation, you should notify the local scheme. Where necessary, an appropriate lawyer will be instructed and, in cases of urgency, you will be invited to contact the lawyer directly so that a meeting or other opportunity for discussion may be arranged as soon as possible. **Members should not approach lawyers direct without first contacting us or our local agents**.

Please note that we cannot accept responsibility for costs incurred by members without our prior authority, nor for costs incurred unnecessarily as a result of a member failing to seek, or act upon, our advice.

When writing to us or one of its agents, you are asked to provide the following details so that we can correctly identify you and protect your confidentiality:

- Your full name, address, qualifications and current daytime and evening contact details. Include email address (or fax details) if relevant, and indicate any preference you have regarding how, when and where we should communicate with you, bearing in mind any confidentiality considerations.

- Your Dental Protection membership number (you will find this on your membership certificate).

Important

Because of legal and ethical Data Protection/Privacy requirements, do not send any records or x-rays to us (neither originals nor copies), nor anything else from which the identity of the patient could be discovered, without our specific instructions. Always contact us first and we will advise you what we need, and what information you are legally entitled to send us (this varies from one country to another).

Members should not give undertakings, negotiate settlements or incur legal expenses without the prior approval of Dental Protection. If you do so, you should not assume that the cost will be met by us retrospectively. An exception may be made in cases of genuine emergency but you should then notify us as soon as possible.

If additional costs which might otherwise have been avoided are likely to be incurred as a result of a member's admission of liability, or any other steps taken by a member prior to contacting us, the member may be asked to contribute towards these costs or pay all of these costs personally. The same is likely to apply where additional, avoidable costs are incurred as a result of a member acting contrary to our advice or taking any step without our agreement while we are conducting a case on their behalf, which complicates or prejudices its outcome.

Feedback

We want you to be happy and satisfied with all aspects of your relationship with us. Please give us feedback on your experiences – whether these comments are positive or negative - and be assured that all such feedback is welcomed, taken seriously by us, and acted upon. If you are dissatisfied with any aspect of the service and support that you receive from us, please let us know. We have a complaints process which is fair, consistent, confidential and responsive and we direct you to the Dental Protection Website for further information.

Professional development with Dental Protection

At Dental Protection we believe prevention is better than cure. We're here to encourage ethical, careful, considerate care by sharing expertise and knowledge on best practice

Our range of professional development services will help you be a safer, more successful member of your dental team. We believe that well informed members are safe members.

- PRISM - Online learning at your fingertips
- Publications – Updating your everyday practice on the latest news and case studies
- Downloadable information and advice booklets on key dento-legal topics
- Tools for clinical audit to support your record keeping
- Workshops eg. professional development, communication skills
- Learning via CD Rom eg. Communication in Dentistry, On the Record (recordkeeping).

PRISM

www.dentalprotection.org/prism

Log in to the e-learning hub and learn at a time and place that suits you. Log your completed courses in your personal profile and print off certificates for your CPD. If your module gets interrupted, just pick up where you left off next time.

Our courses cover a number of key risk areas:

- Dento-legal Issues
- Professionalism and Ethics
- Communication and Interpersonal skills
- Systems and Processes
- Clinical Risk Management
- Reflective Learning

CPD and space for reflective learning

There are learning objectives for all our programmes and you get a certificate for your CPD records to demonstrate your participation. You can also add reflective notes to record your learning and potentially increase your CPD credits in some countries.

"Managing Risk" modules

Video and interactive case studies to highlight the challenging situations and dilemmas that dental teams might be faced with and provides techniques to help you address these difficult situations.

Titles include:

- Clinical Records
- Drugs and Prescribing
- Periodontal Disease
- Under-treatment

These short summaries provide a risk management overview of a variety of clinical procedures. They outline the key risks and provide practical tips for avoiding them, as well as offering guidance on consent and record-keeping issues related to each area of dentistry.

Ethics

A series of 12 short lessons on ethics for dental professionals complied into a single book with an accompanying knowledge check which can also provide three hours verifiable CPD.

This series is intended as a resource for students at the start of their career as well as for dentists who would like to refresh their own understanding of ethics.

Publications

The best of our printed risk management publications are hosted on PRISM.
In addition to the regional editions of *Riskwise* and *Teamwise*, we also have publications for dental students, young dentists and their trainers. You can also find back issues of the *Annual Review*.

Change

This year's *Annual Review* can provide two hours of CPD when you log on to PRISM.

Information booklets

A wide range of risk management resources is available to download from the website, free of charge.

Tools for clinical audit

Addressing some of the most problematical areas of clinical record keeping, these audit tools offer a practical method for reviewing the quality of your clinical records. These guides can be downloaded free of charge from the Risk Management section of the website.

Educational workshops

Throughout 2015, Dental Protection will continue to deliver a series of communication and risk management skills workshops. These three-hour workshops will provide essential skills and insights to reduce the risk of claims and complaints.

Mastering workshops are available in Australia, Hong Kong, Ireland, Malaysia, New Zealand, Singapore, South Africa and the UK.

Mastering Your Risk

Improving communication skills to reduce risk

Take action to help reduce your risk by improving your communication skills and developing techniques to better manage your patient expectations.

96% of previous attendees said that they would change their practice as a result of attending the *Mastering Your Risk* workshop.

By attending this workshop you will:

- Enhance your skills in communicating effectively with patients to reduce risk
- Acquire a deeper understanding of the link between communication skills and patient dissatisfaction
- Gain a greater understanding of the motivation behind patient claims and complaints and why patients sue

Mastering Adverse Outcomes

Dealing with disappointed patients

How you communicate with a patient when something has gone wrong is one of the key factors in determining if a patient will make a complaint or a claim. Yet most dentists receive little or no formal training in how to communicate in what can be a difficult and stressful situation.

The Mastering Adverse Outcomes workshop is designed to fill this gap, providing you with powerful techniques that can reduce your exposure to risk of complaints or claims.

By attending this workshop you will:

- Enhance your skills to communicate with patients when something has gone wrong
- Understand the cultural and legal implications of expressing regret
- Increase your understanding of ethical, regulatory, legal and professional obligations following an adverse outcome including duty of disclosure

Mastering Difficult Interactions

Improve your skills in managing difficult situations

Dentists who received training to improve their communication skills report a significantly lower rate of difficult interactions.

This workshop provides a solution-focused approach to enhancing your effectiveness and ease when dealing with difficult interactions. The skills taught as part of this three hour workshop concentrate on difficult interactions with patients but the techniques learned will be valuable in any difficult interaction.

By attending this workshop you will:

- Enhance your skills in managing difficult situations
- Understand the choices available to you when faced with a difficult interaction
- Learn techniques to minimise conflict and deal with challenging scenarios, such as

Mastering Consent and Shared Decisions

Patients who are well-informed and highly engaged when deciding between treatment options are placed in a stronger position to take ownership of the final treatment decision and outcomes.

During *Mastering Consent and Shared Decision Making* workshop you will examine the principles of consent and the specific skills dentists require in adopting shared decision making. You will learn techniques that can be used to assist in reducing your exposure to complaints and litigation.

By attending this workshop you will:

- Understand the process of shared decision making and its importance in effective dentist-patient relationships
- Gain an understanding of what leads to complaints and claims related to clinical decision making
- Explore the challenges that you could face in the decision making process

For more information on the workshops, including how to book, visit the Events and E-Learning section at www.dentalprotection.org

Learning on CD-ROM

Communication in Dentistry

Dental Protection in conjunction with Smile-on (an international multimedia training provider) has created a set of six interactive programmes to help the whole dental team develop effective communications skills.

Based on solid research evidence, the series strikes an engaging balance between serious content and humorous delivery.

1 The Essentials of Communication
2 Communicating with Patients
3 Communicating with the Dental Team
4 Communication and Consent
5 Communication and Complaints
6 Recording Communications

The complete series is available for purchase on six CD-ROMs which can be used to train and develop new staff members for years to come. Visit www.smile-on.com for more information and to obtain a 20% DPL members' discount on the normal retail price.

On the Record

This 60-minute programme produced in conjunction with Smile-on takes a detailed look at record keeping in dentistry and demonstrates how comprehensive and accurate record keeping supports good dental practice. It is suitable for all members of the dental team at any stage of a career in dentistry. A 20% discount is available for dental members.

Risk Management and Communication

This programme was updated in 2014. It was designed and created by Dental Protection and Smile-on in conjunction with the Faculty of General Dental Practice (UK) associated with the Royal College of Surgeons of England.

Subsidised CPD

The complete set of Key Skills discs is available to dental members at a special discounted price when ordered from www.smile-on.com

Contacts

A national listing for all members subscribing through schemes of co-operation or directly with Dental Protection. A full list of all contacts is regularly updated at www.dentalprotection.org

Australia

Direct membership available in all States and Territories via

DPL Australia Pty Ltd (DPLA)
Level 1, 65 Park Road, Milton, Brisbane 4064, QLD, Australia
Post
PO Box 1013 Milton BC QLD 4064

For membership enquires
T 1800 444 542 (Freecall)
F +61 (07) 3831 7255
E membership@dpla.com.au

For case-related advice
Brisbane office
T 1800 444 542
F +61 (07) 3831 7255

Melbourne office
Level 3, 100 Dorcas Street, South Melbourne, VIC 3205
T 1800 444 542
F +61 (03) 9682 3566

Scheme members
Australian Dental Association branch members in Western Australia and Northern Territory should contact their local scheme representatives:

ADA NT Branch
GPO Box 4496, Darwin, Northern Territory 0801, Australia
T +61 (08) 8982 0407
adant@iinet.net.au

ADA WA Branch
Sue Hurley, PO Box 34, West Perth, Western Australia 6872, Australia
T +61 (08) 9211 5600
F +61 (08) 9321 1757
admin@adawa.com.au

For case-related advice in WA
contact the Dental Cases panel
T +61 (08) 9211 5627
F +61 (08) 9321 1757
cases@dentalcases.com.au

DPLA ABN 24 092 695 933 and CAR No. 326134 is a Corporate Authorised Representative of MDA National Insurance Pty Ltd ("MDANI") ABN 56 058 271 417, AFS Licence No. 238073.

"DPL member" or "Dental Protection member" in Australia means a non-indemnity dental member of MPS. DPL members have access to the Dental Indemnity Policy underwritten by MDANI. By agreement with MDANI, DPLA provides point-of-contact member services, case management and colleague-to-colleague support to DPL members. DPLA is not an insurance company.

Bermuda*

Cox, Hallett, Wilkinson
PO Box HM 1561, Milner House,
18 Parliament Street, Hamilton, Bermuda
T +1 (441) 295 4630
F +1 (441) 292 7880

Caribbean

All enquires* should normally be addressed to Dental Protection, see UK
In an emergency immediate advice may be sought from the local lawyers as indicated*

Anguilla*

Keithley Lake & Associates*
Attorneys at Law, The Law Building, The Valley, Anguilla
T +1 (264) 497 2069

Antigua*

Thomas John & Co*
PO Box 990, FD ICC Building, Lower Factory Road, St John, Antigua
T +1 (268) 460 5860

Bahamas*

Bahamas Dental Association
Annette Warren, PO Box, N1081, 2nd floor, Low Fann House, 53 Collins Avenue, Nassau, Bahamas
T +1 (242) 326 2275
F +1 (242) 326 2260

Higgs & Johnson*
Ocean Centre, Montagu Foreshore, East Bay Street, PO Box, N 3247, Nassau, Bahamas
T +1 (242) 502 5200

Barbados*

Barbados Dental Association
Gertz Plaza, Upper Collymore Rock, St Michael BB14004, Barbados
T/F +1 (246) 228 6488
bdosdentalassoc@caribsurf.com

Carrington & Sealy*
Belmont House, Belmont Road, St Michael, Bridgetown, Barbados
T +1 (246) 436 6700

British Virgin Islands*

O'Neal Webster*
Simmonds Building, 30 De Castro Street, Road Town, Tortola, BVI
T +1 (284) 494 5808

Cayman Islands

Hampson and Company*
Citrus Grove, 5th floor, Goring Avenue,
PO Box 698, Grand Cayman KY1 1107
T +1 (345) 926 8054

Mourants Ozannes*
4th floor, 94 Solaris Avenue, Camana Bay,
Cayman
T +1 (345) 949 4123

Grenada*

Henry, Henry & Bristol*
PO Box 386, 4–6 Lucas Street, St George
T +1 (473) 440 2500/2809

Guyana*

Cameron & Shepherd*
2 Avenue of the Republic, Georgetown,
Demerara, Guyana
T +5 (922) 260 2671

Jamaica*

Karen James
5 Ingleside Drive, Mandeville, Jamaica,
West Indies
T +1 (876) 999 0575
F +1 (876) 962 2901

Livingston, Alexander & Levy*
PO Box 142, 72 Harbour Street, Kingston,
Jamaica
T +1 (876) 922 6310/9

St Lucia*

St Lucia Medical & Dental Association
PO Box GM691, Castries, St Lucia
T/F +1 (758) 451 8441

Chong & Co*
27 Micound Street, PO Box 81, Castries,
St Lucia
T +1 (758) 452 3040/453 2132

St Vincent and the Grenadines*

O.R. Sylvester & Co*
Marcola Plaza, PO Box 951, Halifax Street,
Kingstown, St Vincent and the Grenadines
T +1 (784) 456 1523

Trinidad and Tobago*

Andy Miles
7 Terracita Drive, Lady Chancellor,
Port of Spain, Trinidad
T +1 (868) 625 3051
F +1 (868) 627 2863
agmiles.miles@gmail.com

Hamel Smith & Co*
Eleven Albion, Cnr Dere & Albion Street,
PO Box 219, Port of Spain, Trinidad
T +1 (868) 623 4237/9

Hong Kong

Hong Kong Dental Association
Duke of Windsor Social Service Building,
8/F 15 Hennessy Road, Wanchai,
Hong Kong
T +852 (0)2528 5327
F +852 (0)2529 0755
hkda@hkda.org

Ireland

Local numbers
Membership Helpline
Freephone 1800 509 441

For dento-legal advice
T +353 (0)1280 8668
T +44 (0)207 399 1400
F +44 (0)1132 410 601
enquiries@dentalprotection.org

Israel

Direct, SAM and associate members
Please seek local advice and assistance
from:
Dr Mark Casson, BDS FICD
20 Sderot Hayeled, Ramat Gan,
Israel 52444
T +972 (0)367 28602
F +972 (0)367 00279
markirit@netvision.net.il
or alternatively contact Dental Protection,
see UK

Kenya

The Medical Protection Society Office
Jacky Keith, Nairobi Branch, PO Box
24349, Karen 00502, Nairobi, Kenya
T 020 243 0371
Mobile office +254 (0)722 736 470
mps@africaonline.co.ke

Malaysia

Malaysian Dental Association
No 54–2 Medan Setia 2, Plaza Damansara,
Bukit Damansara, 50490 Kuala Lumpur,
Malaysia
T +60 (0)3 2095 1532/1495
F +60 (0)3 2094 4670
mda@streamyx.com

Malta

Malta Medical Protection Society
PO Box 503, Valletta VLT 1000, Malta
T +356 (0)226 93000
F +356 (0)214 66065
Louise Busuttil Membership Adviser
lbusuttil@charlesdarmanin.com

New Zealand

New Zealand Dental Association
PO Box 28084, Remuera, Auckland 1541,
Building 1, 195 Main Highway, Ellerslie,
Auckland 1051, New Zealand
T +64 (09) 579 8001
F +64 (09) 580 0010
Membership
jill@nzda.org.nz
Assistance
pepe@nzda.org.nz

Singapore

Singapore Dental Association
2 College Road, Level 2, Alumni Medical
Centre, Singapore 169850
T +65 6220 2588
F +65 6224 7967
admin@sda.org.sg

South Africa

Ann Bayman
SADA & DPL Membership Manager
The South African Dental Association
Private Bag 1, Houghton 2041,
South Africa
T +27 (0)11 484 5288
F +27 (0)11 642 5718
abayman@sada.co.za

United Kingdom

Dental Protection Limited
33 Cavendish Square, London W1G 0PS,
United Kingdom
T 0845 608 4000 (UK only)
T +44 (0)20 7399 1400
F +44 (0)20 7399 1401

Dental Protection Limited
2 Victoria Place, Victoria House, Leeds
LS11 5AE, United Kingdom
T 0800 561 1010 (UK only)
T +44 (0)20 7399 1400
F +44 (0)113 241 0601

Dental Protection Limited
39 George Street, Edinburgh EH2 2HN,
United Kingdom
T 0800 561 1010 (UK only)
T +44 (0)131 240 1860
F +44 (0)131 240 1878
enquiries@dentalprotection.org

Office locations

Dental Protection

You can contact Dental Protection for assistance via the website www.dentalprotection.org or at any of our offices listed below

London
33 Cavendish Square, London W1G 0PS, United Kingdom
T 0845 608 4000 (UK only)
T +44 (0)20 7399 1400
F +44 (0)20 7399 1401

Leeds
Victoria House, 2 Victoria Place, Leeds LS11 5AE, United Kingdom
T 0800 561 1010 (UK only)
T +44 (0)20 7399 1400
F +44 (0)113 241 0601

Edinburgh
39 George Street, Edinburgh EH2 2HN, United Kingdom
T 0800 561 1010 (UK only)
T +44 (0)131 240 1860
F +44 (0)131 240 1878

DPL Australia Pty Ltd
Level 1, 65 Park Road, Milton, Brisbane 4064, QLD, Australia
T 1800 444 542
F +61 (07) 3831 7255

Members can obtain verified CPD/CDE after reading this publication by participating in the reflective learning exercise available on the E-learning section of the website www.dentalprotection.org/prism The word **PRISM** used at the foot of a page used throughout the *Annual Review* denotes an article referenced in the online exercise

The cases described in this publication have had some of the details altered to maintain confidentiality of the individuals involved. Pictures in this publication should not be relied upon as accurate representations of clinical situations

Editor: David Croser
david.croser@dentalprotection.org

© Dental Protection Limited

May 2015

Design: www.eightdesign.com
ISSN 1749-5989 (Print)

FSC www.fsc.org MIX Paper from responsible sources FSC® C017270