New Zealand

Dental Protection

Riskwise

Risk management from Dental Protection

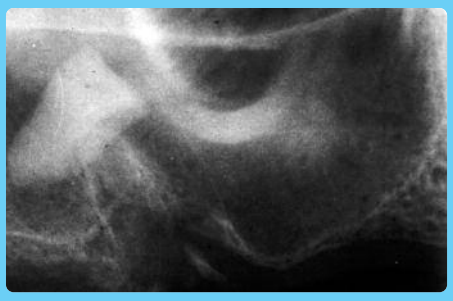
Inside issue 17

Dental implant feature

Learn how to steer clear of avoidable problems 7–12

dentalprotection.org

Contents



Editorial

Dr James Foster
Dental Protection
Head of Dental
Services,
New Zealand

Welcome to the latest edition of *Riskwise* which I hope you will find informative and beneficial

We have focused upon topics of particular relevance for today and also highlighted our range of range of services available.

Regulation

Throughout the world, dental colleagues face an increasing tide of regulation and the associated challenges that accompany that expansion in regulatory activity. The stress and anxiety of an investigation should never be under-estimated, no matter how insignificant the original complaint might first appear.

The Dental Council of New Zealand (DCNZ) has finalised the standards framework for oral health practitioners and it is essential for the dental profession to ensure that it is fully aware of the newly-defined rules against which their actions will be assessed, should an investigation be initiated.

There are three main components to the standards framework, including ethical principles, professional standards and practise standards. Two areas of particular significance are those of consent and competency. In this edition of *Riskwise* we have explored some of the current issues with regard to implants and reference both these important concepts. I hope that you find this and al the other articles in this publication equally helpful.

Matters that do come to the attention of the regulator are varied in nature. However the standards, against which the individual practitioner's actions are measured, are applicable to all. Clearly colleagues who can demonstrate that the required standards have been met are in the best position to achieve an early resolution with minimal impact.

Of course, prevention is better than the cure and I would urge all members to review the range of professional development services which can help practitioners to optimise the quality of patient care in the increasingly difficult environment in which we practise.

Professional development with Dental Protection

- Free CPD
- Lectures and seminars
- Prism - Online learning at your fingertips
- Publications – Updating you with 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
- Small group workshops on communication skills
- Learning online eg. Communication in Dentistry, Record Keeping (www.healthcare-learning.com)

New website

Take a moment to review our recently updated website where you can also find links to all our resources as well as putting online learning at your fingertips.

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 and Ethics
- Professionalism
- Communication and Interpersonal skills
- Systems and Processes
- Clinical Risk Management
- Reflective Learning.

If you have not yet registered with Prism, please do so and have a look through the available material which includes dento-legal issues, professionalism and ethics, communication and interpersonal skills, systems and process and clinical risk management. Colleagues working in remote and rural areas may find this a particularly valuable and convenient method of achieving CPD.

Keeping up to date with clinical matters as well what is expected in terms of professional responsibilities is essential, and as long as we know the standards against which we are measured, then we are in a position to practice safely. I hope you enjoy this edition of *Riskwise*, and once again, please make use of all that is available to you from Dental Protection.

Best wishes,

Dr James Foster
BDS MFGDP(UK) LLM
DPL's Head of Dental Services,
New Zealand
james.foster@dentalprotection.org

A root in the sinus

Dr Mike Rutherford considers the best way of managing such unexpected situations

Prompted by a recent Australian court judgement that awarded a significant sum for a tooth root displaced into the maxillary sinus, Mike Rutherford considers the best way of managing such unexpected situations

This case is a salient reminder that when things go wrong, it can cause a chain of events that lead a long way from the desired and expected outcome. It is also a reminder that such situations demand an early and appropriate referral for expert treatment of your patient. Timely contact with Dental Protection also ensures expert assistance to help you manage the event.

Where did it go?

The displacement of a tooth root into the maxillary sinus is, unfortunately, one of those adverse outcomes commonly reported to Dental Protection. Although specialist removal of the root is, in most cases, accomplished predictably, it is an incident that needs particularly good clinical and patient management. From the patient's perspective, having already undergone the anxiety and trauma of tooth removal, they are now being told that they will require further surgery.

This surgery will be more invasive, more expensive (often involving a general anaesthetic with its accompanying risks and costs), and result in more swelling, pain and bruising than the original tooth removal. Instead of the anticipated afternoon or day off work post extraction, several days' work may now be lost to consultations, day-stay surgery and recovery.

It's in the sinus?

To the general public, most dental procedures are obscure events that are poorly understood. Considerable time and effort may be required to explain just how a root that was once attached to a tooth came to be in a sinus that most people would not expect to be anywhere near their teeth. A patient distracted by the procedure just abandoned and the anxiety of knowing something may have gone wrong is often a poor listener, and will have difficulty taking in the avalanche of new information presented by a dental practitioner who may well be somewhat traumatised themselves by the predicament.

> It is a difficult time for both parties to remain calm and communicate effectively

Most often the difficulties that lead to the displaced root, and the need to manage the accompanying oro-antral damage, mean that the dentist is running late and is probably keeping another patient waiting. Now is not the time to rush.

Take a deep breath, slow down and spend the time with your patient to explain everything fully.

When did it happen?

Most roots displaced into the sinus come from the first permanent molar, with the second molar following close behind. The palatal root is the most common root to be displaced, and the displacement often occurs following decoronation of a molar and subsequent attempts to remove roots that may have been separated either traumatically or by sectioning.

Anecdotally, most displacements occur in 'closed' root removal, that is when a surgical flap and buccal bone removal has not been performed. This may indicate a less successful technique or indicate a less confident operator unwilling to approach surgically. Understandably, relatively less experienced practitioners are over-represented.

Warnings

Information presented before the event is a warning; after the event the same information is often viewed as an excuse or justification.

> Forewarned, your patient is more likely to be accepting of this adverse outcome, particularly if it was discussed as a possibility at the outset

Similarly, acceptance is more likely if the alternatives, including specialist referral, were offered, but a mutual decision was made to proceed with the tooth removal.

You will appear more 'on top' of the outcomes and the procedure if the patient has been forewarned, than if the first the patient knows of this possible outcome is the worried frown on your dental assistant's brow.

Dr Mike Rutherford
Mike has more than 30 years' experience in private practice, hospital clinics, the defence forces and supervising undergraduate dental students. He is also a Dentolegal Adviser in our Brisbane office

We should be acting intuitively and listening to the little warning voice in our head that tells us to "get out of there" – it is the voice of reason

When to stop?

There appear to be three key times when assessment of the situation and referral may prevent this unwanted outcome. Unfortunately the willingness of both the patient and operator to stop the procedure usually becomes less likely at each stage.

The best and most obvious opportunity is on reviewing a preoperative radiograph and assessing the proximity of the sinus. While this may seem self-evident, an honest appraisal of one's experience and the difficulty of the proposed treatment can be hard and is often prejudiced by our patients' expectations and demands, and our own self-confidence. Despite this, a timely referral to a more experienced colleague or a local specialist, accompanied by an assurance that it is in your patient's best interests, is the safest option.

The next opportunity to reconsider is on decoronation of the tooth during a planned simple extraction, and the realisation that the tooth removal has now turned into a more difficult root sectioning or surgical approach. The practitioner and the patient are now involved in a very different procedure requiring a different skill set of the practitioner. If a surgical approach had been assessed as a possibility, your patient should be forewarned of this possibility, and the alternative of a referral offered. The third opportunity arises when a planned approach has not resulted in the removal of the root, and the practitioner finds themselves 'reaching' – that is, retrying techniques with more force, or trying more and more instruments and other approaches not originally planned.

This is potentially dangerous territory, and is generally accompanied by an uneasy feeling - that is the practitioner feels hesitant about the process and indeed unsure whether they should be continuing. In most cases this is eventually followed by success, a feeling of immense relief and a rapid return to a confident demeanour.

Occasionally though the result is disaster – an extraordinary number of dentists reporting root in sinus incidents mention the uneasy feeling they had before the disaster – "I knew I should have stopped" is a common comment. We should be acting intuitively and listening to the little warning voice in our head that tells us to "get out of there" – it is the voice of reason. This is the most difficult time to stop, reassess and refer because of the energy and emotion already invested in the procedure by both dentist and patient, but it is also probably the most important time.

Sometimes other foreign bodies have unintentionally found their way into the maxillary sinus. They require a similar organised response if the patient's best interests are to be protected

A root in the sinus

It happens

If the root has been displaced, excellent clinical and patient management is now essential. Stabilisation of the socket and the accompanying oro-antral communication should be addressed in the first instance using best clinical practice. Once this has been achieved, give your patient and yourself a rest – as previously mentioned you will almost certainly be running late at this stage, but that is very much of secondary concern.

You need your patient to be able to focus on what you are saying, and you will want to be calm and professional in the process. Patients can sense when a dentist appears rushed or anxious. This is a time for your patient to appreciate that you are focused on their welfare and not your next patient.

A patient who may feel aggrieved at the unexpected outcome will undoubtedly feel more so if they perceive a rush to get them out the door. Many a letter of complaint focuses as much on dissatisfaction with the dentist's perceived lack of care post-incident, as it does on the incident itself.

What next?

A prompt referral to a specialist oral surgeon or an oral and maxillofacial surgeon is essential. Surgical retrieval is beyond the scope of most general dentists and normally should not be attempted. In a few cases, small portions of roots may be left in situ - this should, however, be a decision made by an expert third party and not, at the time, by a general dentist whose decision may perhaps be influenced by wishful thinking.

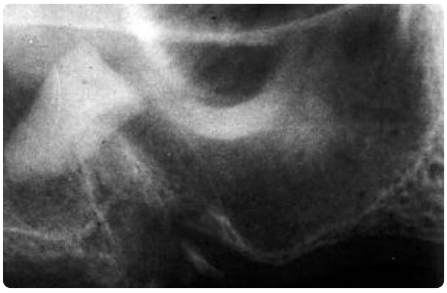
Referral is part of your duty of care and early referral gives your patient the best chance of a favourable outcome. It also removes the possibility of your patient thinking that they have not been told the whole story or have been inappropriately managed. Specialist surgeons are familiar with these situations and can give your patient an expert opinion from a neutral vantage point. If the explanation and advice offered by the surgeon tallies with that already provided by the dentist, validity of both opinions can be reinforced.

And then...

You need advice from one of Dental Protection's dentolegal advisers. Our dentolegal advisers have had the experience of working with many practitioners in similar situations. Although this will probably be an unfamiliar process for the practitioner, the adviser can offer advice based on Dental Protection's wealth of experience in these matters. They offer an independent viewpoint and can advise you how to achieve the best possible outcome for you and your patient, as well as keeping your welfare and reputation in mind.

Self-reproach is a frequent aftermath of such incidents whilst fear of formal complaint proceedings can stifle a practitioner's usual rational patient management. Assistance in maintaining contact with your patient during their remedial treatment, choosing the right words to use, help with a letter of explanation to your patient and recommendations on financial arrangements form part of the advice that is available. It is provided with a view to reassuring your patient that they are being cared for, and ensuring that you meet your duty of care obligations.

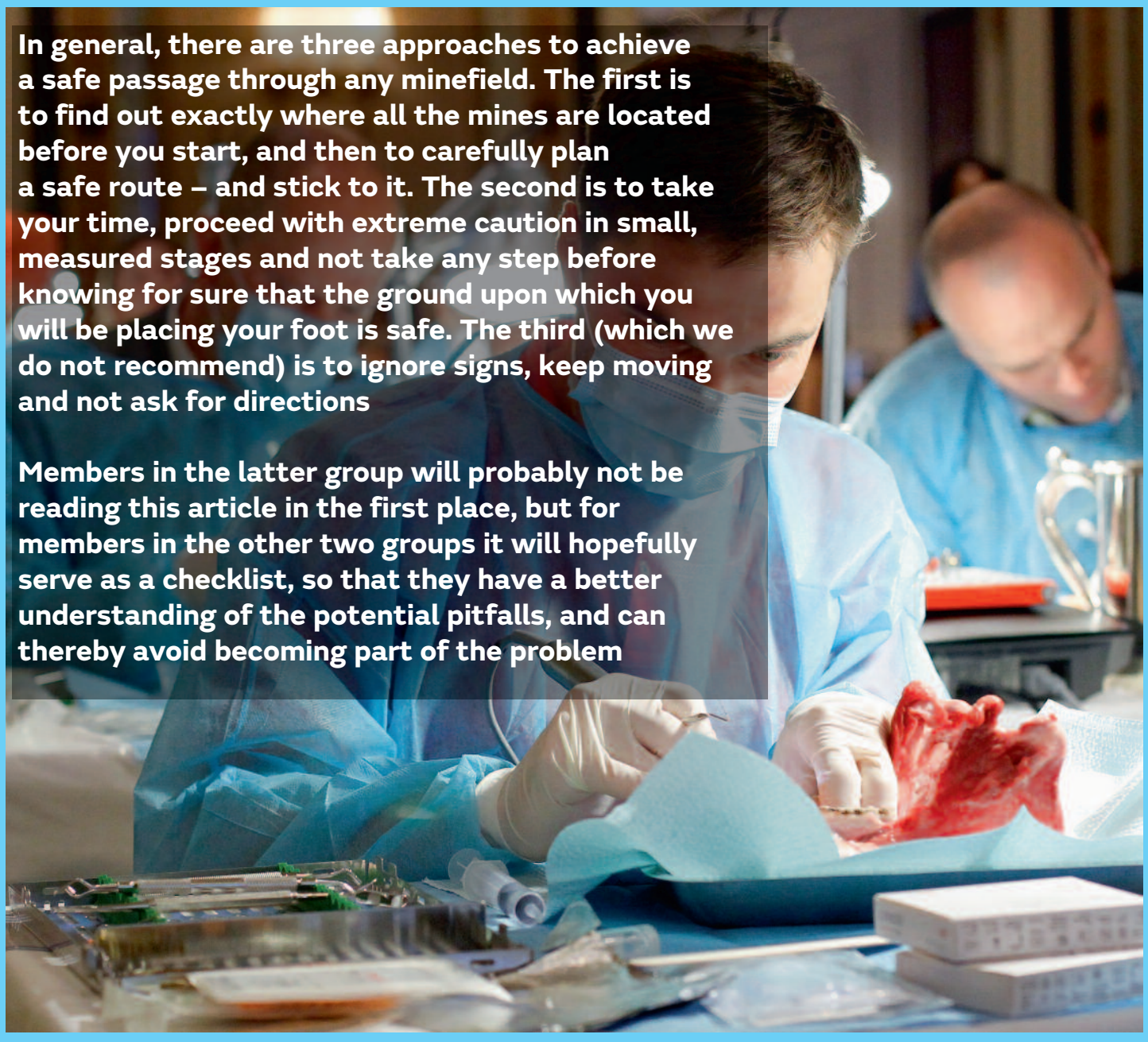
You can't undo what has been done, but you can certainly ensure that the management of the situation is as compassionate and professional as possible, looking after the best interests of the patient, whilst Dental Protection looks after you.



The variable nature of the floor of the maxillary antrum makes it difficult to predict the outcome for every extraction

The minefield of implant dentistry

How to steer clear of avoidable problems



In general, there are three approaches to achieve a safe passage through any minefield. The first is to find out exactly where all the mines are located before you start, and then to carefully plan a safe route – and stick to it. The second is to take your time, proceed with extreme caution in small, measured stages and not take any step before knowing for sure that the ground upon which you will be placing your foot is safe. The third (which we do not recommend) is to ignore signs, keep moving and not ask for directions

Members in the latter group will probably not be reading this article in the first place, but for members in the other two groups it will hopefully serve as a checklist, so that they have a better understanding of the potential pitfalls, and can thereby avoid becoming part of the problem

We are grateful to Nobel Biocare for the use of the images on pages 17–22

The minefield of implant dentistry

Per-Ingvar Brånemark (1929–2014). The Swedish physician regarded as the "father of dental implantology"

Before you start
Get proper training

Short courses, perhaps run by manufacturers and distributors of implant systems are an important part of the training "mix" in order that practitioners can properly understand the features of a particular system, but these bespoke courses can never be a replacement for a broader, extended course which goes into more depth and considers many different implant systems and their relative advantages and disadvantages. Some commercially driven courses may be likely to make the procedure sound simpler and easier, and will not necessarily alert you to the limitations and risks. The aim of such courses is often to promote the merits of one particular system, and to encourage the placement of as many implants as possible, in as many sites as possible, for as many patients as possible, as often as possible. This is not a recipe for sound clinical judgement and practice.

The best courses are generally those which involve formal, structured training provided by acknowledged experts in the field, over an extended period of time (such as one to two years). It will take time, effort and commitment and involve a lot of study. If it doesn't, it invites the question of whether the course is sufficient for its intended purpose. In an ideal world, implant training should involve some kind of examination to demonstrate the attainment of knowledge and competence in the field, and a period of mentoring (ie. the ability to practise implant dentistry under both direct and indirect supervision, where help is readily at hand if you should need it).

It is not difficult to see how exposed a young dentist would be if they get involved in implant dentistry quite soon after qualifying, perhaps off the back of a relatively short course undertaken with no proper curriculum or structure, supervision arrangements, quality assurance or opportunity for hands-on mentoring after completing the course. Any dentist who enters the field of implant dentistry should be prepared to justify the adequacy of any training they have received.

Don't overestimate (or over-state) your competence

When an implant case has gone spectacularly wrong, it can be painfully embarrassing for a clinician to be confronted (during during subsequent discussions) with the way in which s/he had described their experience and training, skill and expertise in implant dentistry (eg. on a practice website). This can be the result of a genuine lack of insight into the level of their own knowledge and competence, or a wish for commercial or other reasons to appear more skilled or experienced than they really are. Either way these exaggerated and misleading claims are not likely to do the clinician any favours and may additionally be a breach of consumer protection regulations and/or of advertising standards.

The tools for the job

Having the correct instrumentation to carry out implant dentistry safely and successfully comes at a price. The highest standards of infection control are essential, and so are good chairside facilities and trained nursing support. If you don't have access to proper imaging (eg. cone beam tomography) in your own practice, establish where and how you can take advantage of this technology if it exists elsewhere (see below). Trying to keep the cost down for a patient by cutting corners, isn't really helping you or the patient in the long run.

Check you have the right protection

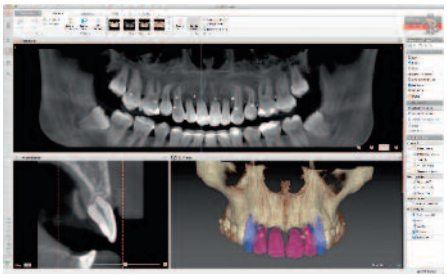
Several different categories apply to implant dentistry and associated procedures such as sinus lifts and bone harvesting from outside the mouth for grafting purposes - it is a member's personal responsibility to check at every renewal date that the category and rate that they are paying is still the correct one. Because these categories can and do change, simply renewing your membership in the same category as the previous year(s) may be leaving you exposed or even unindemnified for implant dentistry.

Getting started
Slow and easy

Suggesting that any implant case is "easy" is probably misleading, but when making for your first foray into implant dentistry, choosing anything other than the least complex case, is asking for trouble. Ideally, taking you time, choosing cases carefully and getting several relatively simple cases under your belt is advisable before attempting anything more ambitious.

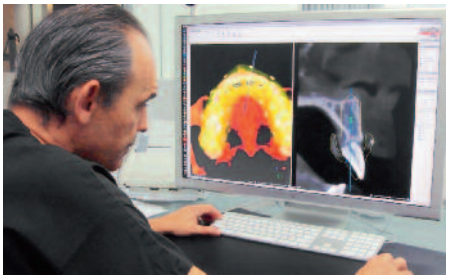
Mentoring

The best introduction is to have an experienced mentor to guide and assist you as you take your early steps into implant dentistry.



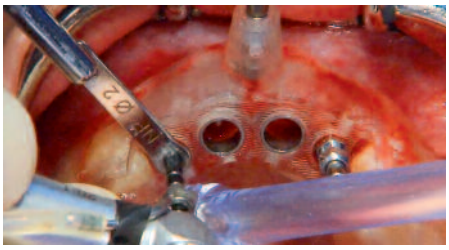
Collecting information about the case

The surgical and prosthodontic phases are best considered as two aspects of a single process, rather than as two separte processes



Planning

Communication with the patient



The right equipment and environment

Sharing care – when more than one clinician is involved

The need for joint case assessment is critical where the surgical and prosthodontic phases of implant dentistry are being carried out by different people.

In implant dentistry, it is helpful if the clinician who will be undertaking the subsequent restorative/prosthodontic phase is present at the time of the surgical procedures.

Implant fixtures are, of course, a means to an end and not an end in themselves. Consequently, implant dentistry needs to be driven, and led, by the prosthodontist – whether this is a specialist or a general dental practitioner. Problems can arise where the prosthodontist is relatively inexperienced in implant dentistry, and the clinician undertaking the surgical phase is more experienced and perhaps viewed as the 'senior' partner in the relationship.

Problems are more likely to arise when there is no over-arching and mutually agreed treatment plan which comprises both the surgical plan, and the restorative plan. The clinician undertaking the surgical phase needs to make it clear what is, and is not possible (or advisable) from a surgical perspective, and the prosthodontist needs to make it clear what is and isn't possible (or acceptable) from the perspective of the subsequent restorative/prosthetic requirements both in a technical sense, and also in order to satisfy the patient's functional and aesthetic needs.

The relationship between the specification and positioning of the implant fixtures, and what could be achieved prosthodontically once they are placed, is so intimate that these two processes need to be viewed as two aspects of a single process, rather than as two separate processes (as so often occurs).

Nowhere is the need for this "seamless" approach more obvious than in the consent process; a patient needs to understand all material facts that relate to the surgical placement of the fixtures, and also to whatever appliance or restoration the fixtures will be supporting. A material fact is one that a patient would be likely to attach significance to, when considering whether or not to undertake the procedure.

The important distinction to stress here, is that one needs to put oneself in the position of the patient, and ask what they might wish or expect to be told – as opposed to what we might decide is important in the context of one or other stages of the overall process itself. Consent is more likely to be sound if the process is patient-focused rather than procedure-focused.

The fact that two clinicians might be involved in the same case can actually be used to reduce the risk, rather than increasing it, because two different perspectives and two different sets of experiences can be brought to bear upon the consent process. This benefit will only be felt, however, if the two parties are communicating with each other and they both feel able to make an active contribution to the debate.

For as long as surgeons and prosthodontists (or general dental practitioners) take the view that they have no input into, nor responsibility for, the role of the other, then patients will continue to fall between the two zones of control. By working to eliminate that gap through closer communication and mutual consultation, the two parties can best serve the patient, themselves and each other.

The minefield of implant dentistry

Case assessment and treatment planning

Plan carefully

At least a third of all implant cases that are seen by Dental Protection can be traced back to some kind of deficiency in the case assessment and treatment planning stages like those listed below.

In particular

- Any sense that a clinician has rushed headlong into the placement of implants without allowing time to get to know the patient and/or consider and discuss any other treatment options.
- The absence of an up-to-date medical and medication history or an apparent disregard of any absolute or relative contraindications associated with either of them (eg. Type 1 diabetes, or any medication affecting bone metabolism or density, the inflammatory response or the tendency to bleed).
- A failure to elicit or act upon relevant features of the patient's dental history – for example a history of chronic periodontal disease.
- A failure to screen for, assess and manage any relevant risk factors, especially smoking.
- Inadequate preoperative investigations (models, x-rays and other imaging etc).
- A failure to seek and act upon advice from others (including specialists) where appropriate.

Minimise risk and uncertainty

The maxim "*Predictability is the key to tranquillity*" applies to many stages in the provision of implant dentistry, but perhaps especially so in anticipating the potential risks and complications at the site where fixtures are to be placed. Conventional radiographs suffer the disadvantage that they give us a two dimensional image of what is actually a three dimensional situation. We make allowances for this as far as we can, and have developed techniques (such as the parallax technique) to compensate for the limitations of a static view from a single perspective.

Having a 3-D view or a multi-perspective view – by using computerised axial tomography (CAT scans) including cone beam CT or magnetic resonance images (MRIs) - transforms our knowledge base, removes a lot of the uncertainty and guesswork, and sometimes makes us aware of potential hazards that we would otherwise have been unaware of. Fewer surprises for the clinician will generally mean fewer surprises for the patient, which is a good thing.

While there is always a cost attached to new technology, and one must be mindful of the obligations of the codes of safe practice for radiation use (www.health.govt.nz) it is not for the clinician to deny the patient the opportunity to decide for themselves whether or not they wish to incur the additional cost of having this additional imaging carried out. Equally, if the patient is unwilling to undergo this further imaging on cost or other grounds, the clinician has the right to decline to provide the treatment.

If an adverse outcome could have been anticipated and avoided by the use of additional imaging, the questions arise of whether a reasonable body of professional opinion amongst those working in the field of implant dentistry would support the view that:

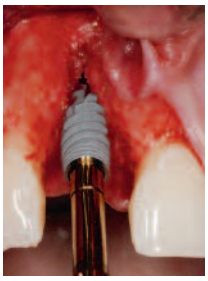
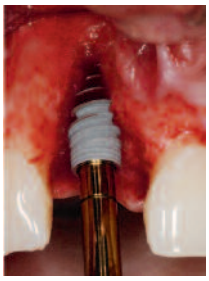
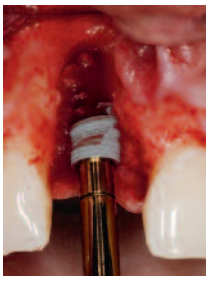
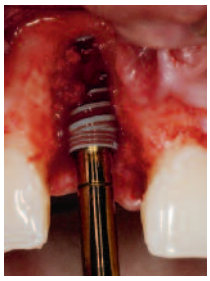
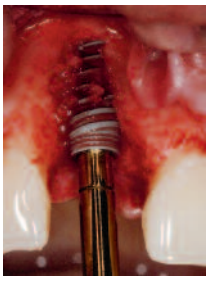
a the additional imaging was (or was not) necessary in the circumstances of the specific case,

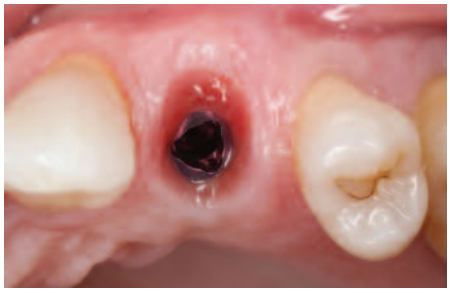
b a responsible clinician acting in the patient's best interests would proceed with placing the implants without the additional imaging being available.

Another example of a step which improves predictability and reduces uncertainty (especially in an edentulous arch) is the use of stents and other forms of surgical guides where appropriate, and in more complex cases, the construction and use of surgical models.

Spend time validating consent

The patient should be aware of the purpose, nature, likely effects, risks, and chances of success of a proposed procedure, and of any alternatives to it. The fact that a patient has consented to a similar procedure on one occasion, does not create an open-ended consent which can be extended to subsequent occasions. Consent must be obtained for specific procedures, on specific occasions.

Some questions to ask yourself to help ensure the patient's consent is valid

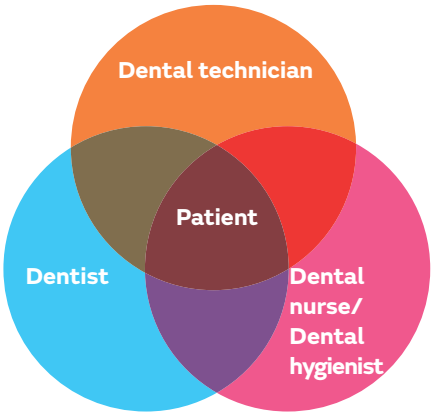
- Is the patient capable of making a decision? Is that decision voluntary and without coercion in terms of the balance/bias of the information given, or the timing or context of its provision?
- Does the patient actually need the treatment, or is it an elective procedure? If an elective procedure, the onus upon a clinician to communicate information and warnings becomes much greater. (*Placing an implant in a site where a tooth has been missing for several years, without replacement, would be an example of this*).
- What do I think will happen in the circumstances of this particular case, if I proceed with the treatment? Have I communicated this assessment to the patient in clear terms? Can I give an accurate prediction? If not, is the patient aware of the area(s) of doubt?
- What would a reasonable person expect to be told about the proposed treatment?
- What facts are important and relevant to this specific patient? (*If I don't know, then I am probably not ready to go ahead with the procedure anyway*).
- Do I need to provide any information for the patient in writing? Has the patient expressed a wish to have written information? (*Am I relying upon commercial marketing material produced by manufacturers and/or suppliers? If so, is this information sufficiently balanced in the way it is presented?*)
- Does the patient understand what treatment they have agreed to, and why? (*by way of illustration, when a general practitioner is proposing a crown to be supported on an implant fixture placed in association with a bone graft, under sedation and local anaesthesia, this requires all the aspects of a proper consent procedure to be covered for each of the six aspects highlighted – because there are risks and limitations, alternatives and other considerations associated with each of them, that the patient needs to understand before proceeding. Some patients may object to certain or any forms of bone grafting on religious or other grounds*)
- Have they been given an opportunity to have any concerns discussed, and/or have their questions answered? Do the records support this?
- Does the patient understand the costs involved, including the potential future costs, in the event of any possible complications?
- Does the patient want or need time to consider these options, or to discuss your proposals with someone else? Can you/should you offer to assist in arranging a second opinion?
- If you are relatively inexperienced in carrying out the procedure in question, is the patient aware of this fact? Are they aware, (if relevant) that they could improve their prospects of a successful outcome, or reduce any associated risks, if they elect to have the procedure carried out by a specialist or a more experienced colleague?
- If the technique (or implant system) is relatively untried or of an experimental nature, has the patient been made aware of this? Included here are any procedures for which the evidence base is limited or absent, including systems which trade on the published evidence relating to similar systems without actually being supported by any evidence base of their own.

The surgical phase - placing the implant fixtures

- **Give appropriate pre-operative advice**
- **Follow accepted procedures**
  Stay within the limits of your training and competence.
- **Recognise when things are not going to plan**
  Take appropriate steps to recover the situation which in some cases may involve referring the patient for specialist advice and care.
- **Give appropriate postoperative advice and warnings**
  Inform the patient about the need for early reporting of any indications of possible nerve injury. In these cases speed is of the essence and the longer you spend keeping the situation under review with the fixtures still in situ, the worse the prognosis.
- **Review the patient**
  Choose appropriate intervals following the procedure and especially in the days immediately following the placement of the implant(s)

Regular monitoring of the bone height and soft tissues adjacent to the restored portion of the implant will alert you to the first signs of peri-implantitis

The minefield of implant dentistry



Well-rehearsed teamwork optimises clinical outcome for the patient

The prosthodontic stage

It is beyond the scope of this article to cover all the variations of fixed and removable prosthodontics that can be supported upon implant fixtures, nor all the considerations regarding immediate or deferred loading. Many of the potential complications attributable at first sight to the prosthodontic stage (aesthetics, function, soft tissue problems at the "neck" of the implant, maintenance problems etc.) can be avoided if sufficient time and attention is applied to the case assessment and treatment planning stages.

Perhaps the best generic description of the root cause of many of the problems, is that inexperienced clinicians will sometimes wrongly assume that supporting crowns, bridges and appliances on implant fixtures, is essentially the same as placing them on natural teeth.

Follow up and monitoring

Maintenance

It is essential that patients should be helped to realise that implants need to be looked after just as carefully as natural teeth. Meticulous oral hygiene, with techniques adapted to the specific needs of each patient, and (where applicable) continued encouragement to maintain smoking cessation, are crucial ingredients of implant maintenance.

Patients must understand that attendance as recommended for review purposes will help to minimise problems in the months and years following implant placement. They must also accept responsibility for the potential consequences of not doing so.

Keep your eye on the ball

Implants, once placed, are a long-term commitment for both the patient and the clinicians who are responsible for their on-going care. The condition becoming known as "Peri-implantitis" is a growing problem not just for the clinicians who originally placed the implants or placed restorations or appliances upon them, but sometimes for others who had no part in the original treatment, but end up caring for the patients in the years following the provision of that implant dentistry. This includes both dentists and dental hygienists.

Peri-implant mucositis is an inflammatory condition which in its early stage is reversible. There will be redness, swelling, inflammation and the tissues around the fixture will not look healthy. At this point there is no bone loss. Improved oral hygiene and better care of the implants will usually reverse or improve the condition. There is an abundance of evidence to suggest that the presence of keratinised gingival tissue at the "neck" of the implant at the point of emergence into the oral cavity is a desirable, protective situation which makes the initiation and further progression less likely.

Left uncontrolled, the inflammatory condition can progress to peri-implantitis andloss of crestal bone, often creating a characteristic dish-shaped bony defect which is clearly visible on radiographs. Careful comparison of such radiographs over time allows the situation to be assessed. Once peri-implantitis has become established, it is very difficult to treat.

A failing implant will continue to fail if no proactive attempt is made to rectify the situation. Clinicians who played no part in the placement or restoration of the implant can wrongly assume that they cannot be held responsible for the failure – but they can be held responsible both for failing to identify the signs that the implant is failing, and the failure to seek advice from colleagues who have more experience in implant dentistry.

Summary

Meticulous records

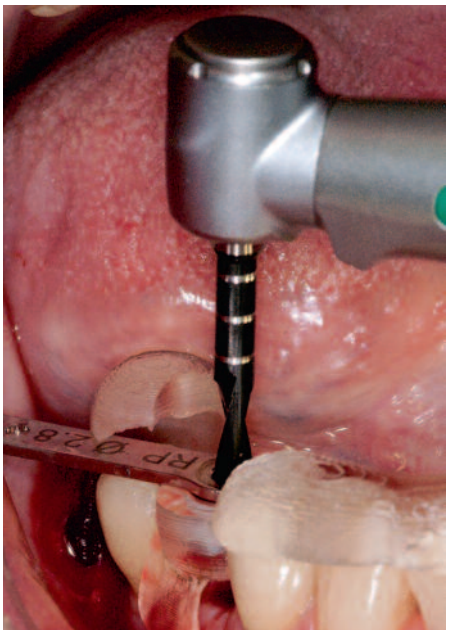
In implant dentistry, every stage of the process needs to be very carefully recorded. Especially important here are records of what the patient was led to expect, what information was provided to the patient, what warnings they were given etc.

Your records must meticulously document every detail of the histories taken, the exploration of any possible risk factors that might affect the prognosis, any tests and investigations carried out, any liaison with professional colleagues, and all discussions with the patient.

Detailed records also need to be kept to demonstrate the careful monitoring of the status of the implants (both hard and soft tissues) in the months and years following their placement.

Stay up to date

Implant dentistry continues to be a dynamic and evolving field. Ensure that you keep your knowledge and skills up to date and be prepared to adjust your approach when necessary.



Smoke and mirrors

Some simple steps for the dental team to follow, to drive home an important message

The link between tobacco smoking and the health of the soft tissues in and around the mouth (and beyond) is well known within the dental profession and also well documented. Unfortunately, it is not well understood by many at-risk patients despite all the public health messages designed to improve that awareness. Your involvement in discussing the risks of tobacco use will be in the best interests of the patients concerned, it will also help to protect you from dento-legal threats and challenges

Know your target audience

The better you know and understand what makes a patient tick, the easier it becomes to align your message to the things that matter to them, and are likely to influence their thinking, attitudes and behaviour. Different patients are motivated by different things, and the same patient may respond differently according to what else is happening in their life when you broach the subject.

Establish the facts and check them regularly

Try to establish the patient's actual tobacco usage. Is it stable, increasing or decreasing? Has the patient ever tried to reduce or stop their smoking in the past and if so, how many times, using what approach and with what degree of success? Do they genuinely want to stop smoking and if so, why?

Plan your message

Pick your moment when you have the patient's full attention, free from other distractions, and work out in advance what you plan to say and how. It is more likely to be effective if you do.

Deliver the message in context

Look for ways to discuss the subject in a specific context that can provide relevance and emphasis, such as immediately following an intra-oral mouth cancer screening check or when discussing the cost of treatment, the longevity or success of which might be compromised by continuing to smoke. Let the patient know what the likely consequences of continuing to smoke are for their general health and in the specific context of their oral health and any treatment that they are receiving or about to undertake. Link their smoking to other risk factors to demonstrate the cumulative risk to which they are exposing themselves.

Repeat and reinforce your message

Don't assume that by delivering your message once, that it will be acted upon. There is a now a research-based cognitive model for predicting patient compliance. This has identified guidelines for improving patient's understanding and recall of information which, in turn, leads to better patient engagement/involvement and increased compliance, and well as increasing patient satisfaction. Philip Ley who pioneered this research in medicine suggested that the content of oral communication and patients' subsequent recall can be improved with the following strategies:

- Use the primacy effect – patients have a tendency to remember the first things they are told; it is processed in short-term memory with relatively little proactive interference.
- Stress the importance of compliance (leave no room for the patient to misunderstand or fail to appreciate the consequences of non-compliance). Make it personal and specific.
- Simplify the information; reduce the amount and don't use jargon.
- Use repetition. Ask the patient to confirm the main points.
- Be specific
- Reinforce and supplement information provided verbally by providing it in written form too if possible.

Attention to these factors can significantly increase patient recall thereby increasing patient compliance.

Follow up at appropriate intervals

If you send the patient the signal that what you talked about at a previous visit is not important enough to follow up, you should not be too surprised if they attach very little importance to it. Following up these conversations in a planned and structured way gives you another opportunity to check on progress and reinforce the messages.

Keep detailed records of every smoking cessation discussion

Instead of a general entry which simply records that smoking cessation advice was given, try to place the advice in context ie. periodontal disease, implant provision or maintenance, oral cancer risk etc.

Record any undertakings or commitments made by the patient, and/or any indication by the patient that they were unable or unwilling to commit to smoking cessation or to try to reduce their tobacco usage. Don't leave your records of these conversations open-ended; if you warn the patient of the risks of not following your advice, be sure to include a note to that effect.

Resources
The New Zealand Guidelines for Helping People to Stop Smoking
www.health.govt.nz
http://www.quit.org.nz/
http://smokefree.org.nz/

In the medicine cabinet

Professor John Gibson highlights recent pharmacological developments that are already having an impact on dental patients

Background

It seems that there has never quite been a time like this for medical advancements – both diagnostically and therapeutically. The result for the dental team is that there are more and more orofacial manifestations of systemic diseases to be aware of and recognise, also more and more drug therapies that you need to have a handle on regardless of who writes the prescription

To whet your appetite, let me introduce you to some of the challenges currently evident at the medical-dental interface.

Metformin and vitamin B12 deficiency

For example, did you know that metformin, the commonly prescribed oral anti-diabetic drug, has recently been shown to cause vitamin B12 deficiency (Ko *et al*, 2014)? Vitamin B12 deficiency can present with myriad oral manifestations, including macroglossia, glossitis, oral ulceration and angular cheilitis. Maybe, you will be the clinician who diagnoses these signs and suggests the underlying aetiology in your cohort of patients with the increasingly common condition of Type 2 diabetes mellitus?

Chlorhexidine

One of the current concerns in medicine is the increasing prevalence of hypersensitivity ("allergic-type") reactions. Until recently, chlorhexidine would not have figured in the list of substances of concern within dental practice. For chlorhexidine, Type IV hypersensitivity (i.e. delayed) reactions on the skin have been documented for years but are rare. Type I hypersensitivity (i.e. anaphylactic) reactions have been reported where application has been made to broken skin and the urethra, vagina and eyes.

Prior to 1970, no reactions had been reported within the oral cavity, but a number of Type I and Type IV reactions have been reported since, to both solution and gel preparations. In more recent times (2009 and 2011), there have been two UK deaths in dentistry apparently due to chlorhexidine by anaphylaxis – a 63 year old male and a 30 year old female. Both cases appear to have resulted from irrigating sockets with chlorhexidine after dental extractions. In each case, the Coroner reported: "accidental death due to an allergic reaction" and "death by medical misadventure due to anaphylaxis" (Pemberton and Gibson, 2012).

Shortly after the second such tragic death, the UK Government's Department of Health issued a warning via its Medicines and Healthcare products Regulatory Agency (MHRA) drug safety update: *Chlorhexidine: reminder of potential for hypersensitivity* (DOH, London, 2012).

A similar warning was also published on your own Medsafe website (www.medsafe.govt.nz) and it is worthwhile revisiting the recommendations offered there, whilst reminding ourselves that open wounds seem to increase the likelihood of an allergic reaction. Therefore, it would seem sensible not to irrigate sockets with chlorhexidine; and, further, to advise all patients when you issue a prescription or a product containing chlorhexidine of the possibility of an allergic reaction and to document this warning in the patient's record.

Although chlorhexidine should be viewed as a relatively safe substance which has been in use within dental practice for many years, it is timely to remind ourselves that patients should only be advised (or prescribed) any product when there is a clear clinical indication and the benefits outweigh any potential risks.

Professor John Gibson PhD BDS MB ChB FRCP(Glasg) FDS(OM)RCPS(Glasg) FFDRCS(Irel) FDSRCS(Ed)
John is Professor of Medicine in Relation to Dentistry and Honorary Consultant in Oral Medicine, University of Glasgow Dental School & NHS Greater Glasgow & Clyde

John is Chair of the Board of Dental Protection

Oral contraceptives and antibiotics

It is always thought-provoking when "tried and tested" advice which has been incorporated into conventional clinical practice over many years is challenged by up-to-date knowledge. It is particularly challenging when such original advice has been generated by oneself! This was the case with the advice on the use of oral contraceptives and the potential interaction with antibiotics suggested by myself in 1994 (Gibson and McGowan, 1994): *when prescribing a broad-spectrum antibiotic, recommend to patients to use a barrier method of contraception whilst taking the antibiotic and for seven days after stopping.*

Since then, Taylor and Pemberton (2012) have challenged this view, highlighting that 25% of women in the UK (aged 16-49 years) use the oral contraceptive and that there are two chief types of hormonal contraception:

- Combined (oestrogen and progestogen – "monophasic" and "phasic"); 21 day cycle with 7 day break
- Progestogen-only; taken continuously.

Current thinking is that oestrogen works by stopping ovulation and progestogen works by thickening cervical mucus (thus decreasing the passage of sperm) and thinning the endometrium (thus preventing embryo implantation).

Taylor and Pemberton state that antibiotics may be classified as:

- Enzyme inducers: which induce the cytochrome P450 enzyme in the liver and so oestrogens are destroyed more rapidly; or
- Non-enzyme inducers: with no effect on progestogen and minimal effect on oestrogen.

The majority of antibiotics (and, indeed, all those in use in conventional primary dental care) are non-enzyme inducers and so the Faculty of Sexual and Reproductive Healthcare (of the Royal College of Obstetricians and Gynaecoloists in the UK) issued new guidance (2011), such that, "*additional contraception precautions are not required even for short courses of antibiotics that are not enzyme inducers when taken with combined oral contraception*".

Similar advice has been given by BPAC (www.BPAC.org.nz). In addition, advice for women who are prescibed enzyme inducing drugs is available from the New Zealand Medicines Formulary. (www.nzf.org.nz).

Sleep apnoea

Patients seem to be complaining more commonly about symptoms of dry mouth – often due to the complexities of drug regimens – but we should always bear in mind the possibility of underlying systemic disorders such as Sjogren's syndrome.
One such complex disorder – is sleep apnoea which may have both local (muscular) and systemic origins. Its complexities demand that the diagnosis of sleep apnoea is established in all cases by a medically-qualified specialist in sleep medicine. The major symptom of sleep apnoea is daytime sleepiness, measured by the Epworth Sleepiness Scale.

There is some suggestion that sleep apnoea, when left untreated, may increase the risk of hypertension, cerebrovascular accident, type 2 diabetes mellitus, mental health morbidity, and possibly myocardial infarction (Loke et al, 2012). Accordingly, identifying patients with sleep apnoea is important and dentists may first find such individuals through the symptom of dry mouth.

Further questioning may reveal fatigue and daytime sleepiness, and the consideration of discussion with the patient's GP regarding referral to a Sleep Medicine unit. Appropriately trained and experienced dentists may subsequently be involved in managing patients with diagnosed sleep apnoea in providing oral appliances (e.g. mandibular repositioning appliances).

Regardless, where patients with sleep apnoea show evidence of dry mouth, additional preventive measures may be encouraged to reduce the risk of caries and tooth loss. Where patients are prescribed oral/nasal masks by sleep medicine physicians to provide CPAP (continuous positive airway pressure) to keep the upper airway open and thus prevent apnoeic episodes, oral dryness may, again, be experienced. Such patients should also be offered augmented preventive advice.

References
Ko S-H et al. Association of vitamin B12 deficiency and metformin use in patients with type 2 diabetes. J Korean Med Sci 2014; 29: 965-972
Pemberton MN and Gibson J. Chlorhexidine and hypersensitivity reactions in dentistry. Brit Dent J 2012; 213: 547-550
Gibson J and McGowan DA. Oral contraceptives and antibiotics: important considerations for dental practice. Brit Dent J 1994; 177: 419-422
Taylor J and Pemberton MN. Antibiotics and oral contraceptives: new considerations for dental practice. Brit Dent J 2012; 212: 481-483
Loke YK, et al. Association of obstructive sleep apnea with risk of serious cardiovascular events: a systemic review and meta analysis. Circ Cardiovasc Qual Outcomes 2012; 5: 720-728
www.bpac.org.nz/BPJ/2012/november/apnoea.aspx

Prism

Ben Simpson is responsible for providing Dental Protection's online educational content. Here he anticipates a future development for this valuable member resource

Whilst it's difficult to predict what the future holds for people accessing education, we can safely assume that the use of online technologies and e-learning will increase

Over the last five years we have seen a steady increase in the demand and uptake of online education from dental members and this is not a trend that shows any sign of slowing down.

Being responsible for Dental Protection's online education, I am aware of the obligation to provide education of a certain quality and standard. This is not only about content but about the technology being used to access that content. There was a time when learning at a "time and place that suits you" meant being sat at a computer or laptop. Members today want access 'on the move.' They access websites via a whole host of mobile devices, so we need to ensure the experience of our courses on those devices is a positive one.

To illustrate what we are doing to keep our e-learning up-to-date, let's take the risk management modules – the first online modules available to download from the Dental Protection website. These took the form of a PDF document that could be studied before the reader answered questions based on the content. When these were revised, five years ago, there was an opportunity to further develop the presentation of the material; after reading about a particular topic, the reader can now be tested on their understanding of that subject before moving to the next module.

Technology moves swiftly, and with it the expectations of learners become greater, which is why we have replaced some of the modular library with the Managing risk series. After updating the content covering the same key risk areas in dentistry, we have added video, animation, reflection points, and a short test to check that the clinician has understood the material throughout the module. This offers a much more fluid and effective learning experience.

But it doesn't stop there. Video and animations work differently depending on the device on which they are viewed. Will it work on my iPad? Will it work on my smart phone?

PCs v tablets: past and forecast

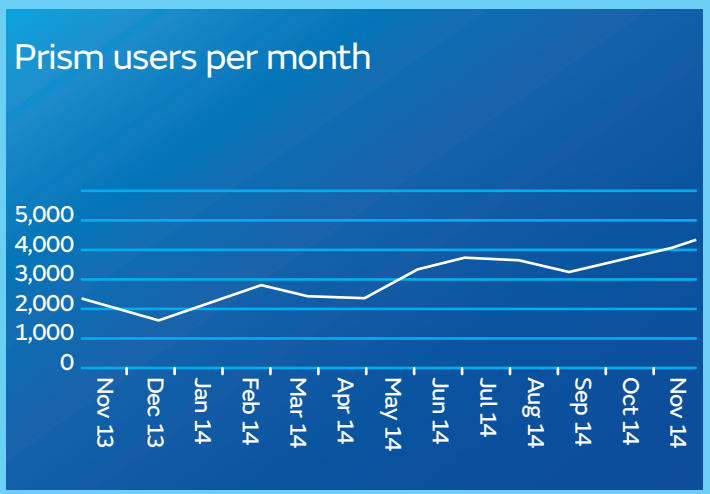
PC (white) v tablets (green) – IDC forecast for shipments by year through to 2017. Figures from 2013 onwards are forecast.

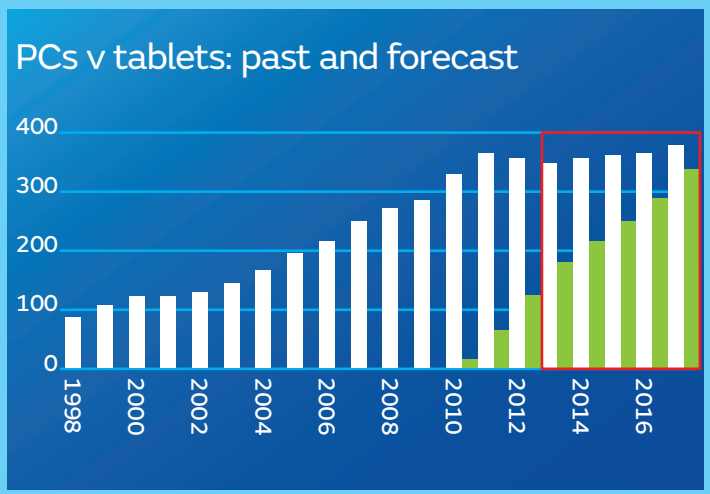
The challenge of providing multi-device content in a world of rapidly-evolving technology is something that we have been working on. Our PRISM e-learning platform is now mobile friendly and so are the majority of courses. Those courses that are not yet optimised for all devices are clearly labelled and are part of an on-going programme of updates.

If you haven't done so already, why not take a look at the courses on our PRISM e-learning platform? Access is completely free for dental members. www.dentalprotection.org/prism

Any questions?

elearning@dentalprotection.org





PC (white) **v tablets** (green) **– IDC forecast for shipments by year through to 2017. Figures from 2013 onwards are forecast** (red)
Source IDC

Shared decision-making rather than sharing "a decision made"

We increasingly hear the term *Shared Decision Making* being used and promoted, but what exactly does it mean and what are its benefits?

The increasing sophistication of dental care with an expanding number of available treatment options, set in the context of patients with rising levels of expectations, has made decision making more complex and challenging for both the dentist and their patients. Added to this is the additional dimension of cost. Its perhaps not surprising that a model of decision making that takes account of these issues, incorporates ethical and legal requirements, respects many patients' increasing desire for involvement while also incorporating the knowledge and expertise of the dentist has emerged.

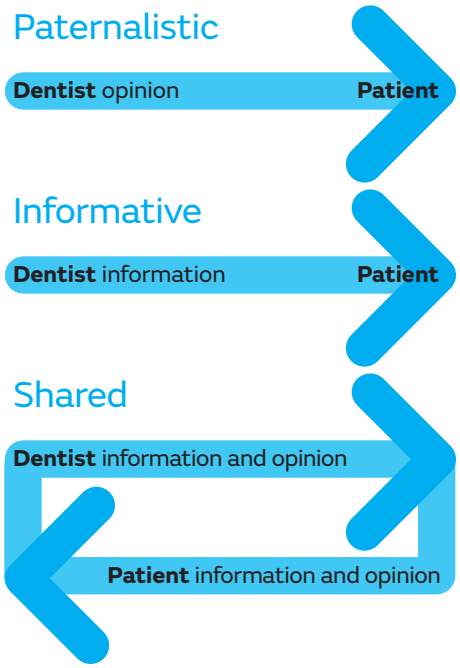
Consent and decision-making

The requirements of the discussion process that contributes to the validity of consent have changed significantly over the last 30 years. Neither a paternalistic/prescriptive model of "the dentist knows best" nor simply an informative approach of "Here's all the information, you decide" fulfil the requirements of a decision making process outlined above. These two styles are different from making the decision in partnership with the patient where there is an exchange of knowledge and opinion (see box 1). It is the discussion around the consent process that is likely to satisfy patients' needs, enable patient autonomy and reduce the risk of complaints and claims resulting from patients alleging that they had not been properly informed.

The challenge for many of us is that a wise decision isn't dictated by science and clinical expertise alone, but requires consideration of the patient's perspective. It also requires dental team members to move from the "general" ie. what might be the right decision for the majority of patients; to the "individual" ie. what is the right decision for this particular patient. The only way to achieve the latter is to ask the patient what matters to them. Dentists contribute their expertise and experience around diagnosis, disease and evidence based treatment while the patient contributes expertise about what matters to them as patients such as their preferences, values, attitudes to risk, concerns and expectations reflecting past experience. (See box 2)

Box 1

Type of decision making



Box 2

Examples of patient values (what is important to the patient):

- Short-term relief of dental symptoms
- Long-term solutions for their oral health
- Cosmetic appearance
- Functional improvement
- Cost

Dento-Legal risk and decision-making

Most dissatisfaction with clinical decision-making relates to:

- The amount and quality of information received
- Their level of involvement in the decision-making process.

The vast majority of patients want to be offered choices and asked their opinions[1, 2].

Risk related to clinical decision-making is greater in certain situations (see box 3). The more of these that apply, the greater the risk

Decision-making carries more risk in the following situations

- Elective treatments
- Patients with high aesthetic/cosmetic demands
- No dental consensus
- Multiple treatment options
- Potential for significant adverse outcome/additional cost

1 Chung, G.S., Lawrence, R.E., Curlin, F.A., Arora, V. & Meltzer, D.O. (2011). 'Predictors of hospitalized patients' preferences for physiciandirected medical decision-making.' Journal of Medical Ethics (Online First): available: http://jme.com/content/early/2011/06/22/ jme.2010.040618.abstract. Accessed 27 February 2013

2 Levinson, W., Kao, A., Kuby, A. & Thisted, R.A. (2005). 'Not All Patients Want to Participate in Decision Making.' JGIM,20(6):531-535

Shared decisions

Box 3

Decision making carries more risk in the following situations

- Elective treatments
- Patients with high aesthetic/cosmetic demands
- No dental consensus
- Multiple treatment options
- Potential for significant adverse outcome/additional cost

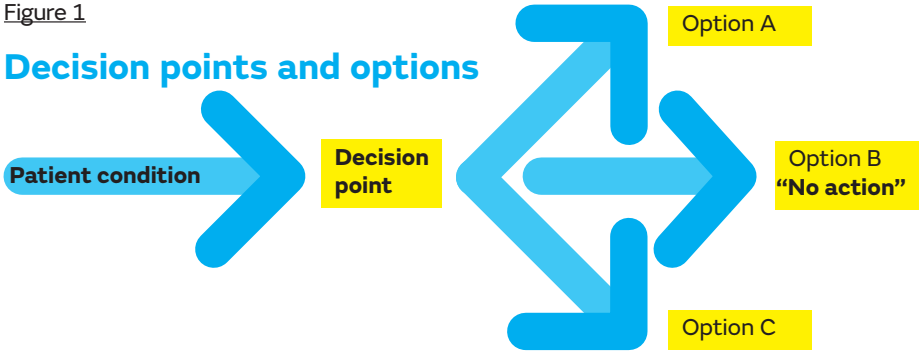
Numerous studies have shown that clinicians' assumptions of patient values on which they may base their recommendations. Better informed patients often make different choices eg more conservative treatment and are more risk averse. What patients want is often different from what clinicians think their patients want[3,4,5]. The literature also suggests that when patients make these decisions they are more satisfied[6].

Often we decide what we think is in the patient's best interest from a clinical perspective, inform them as to why we have arrived at that decision and then give them details of the risks and benefits. This represents more persuasion than collaboration, i.e. making decisions for rather than with the patient. The danger is that the patient may feel that they have been pushed into care or treatment that they did not want.

If we view a patient's condition as a healthcare journey over time (see figure 1), at the decision point there are a number of options. If option A is associated with an adverse outcome and they feel worse off than before treatment, the patient may well reflect as to why they had any intervention at all (given that it was elective) and that perhaps they would have been better with "no action" or conservative management (option B), a different option (option C) or even an option they weren't told about.
An important task of the decision making discussion is to help the patient arrive at an appropriate understanding of the risk/benefit analysis of each option, including the option of doing nothing and to compare these in the context of their own values, preferences and expectations of treatment.

Figure 1

Decision points and options



Patient preferences for involvement in decision making

Resistance to shared decision making often revolves around a perception that dentists have many patients who wish the dentist to make the decision for them: "Whatever you think best". The difficulty is that just as Dentists have preferences for their style of decision making, patients also have preferences as to their desired level of involvement (see figure 2). This is context dependant and can change with time. For example a patient's desire to be involved in an elective procedure is likely to be very different than if they are in severe pain such as with a large abscess when they may be only too willing to devolve decision making responsibility to the dentist.

Regarding the passage of time, should the patient experience an adverse outcome from their treatment, perhaps involving significant extra cost, their preference about how much they should have been told and involved may well be different in retrospect.

Of course the recommendation of the dentist may be the most important piece of information that helps the patient arrive at a decision. However, that recommendation should only be made when the patient's perspective (values, preferences, concerns and expectations) have been established.

The General Dental Council in its Standards for the Dental Team (2013)[7] says "*You must recognise and promote patients' rights to and responsibilities for making decisions about their health priorities and care.*"

The NHS Constitution[8] (updated 2013) says: "*You have the right to be given information about the test and treatment options available to you, what they involve and their risks and benefits.*"

What is shared decision making?

Shared decision making is both a philosophy and a process whereby the patient and professional work in partnership to make decisions about care where there is more than one beneficial way forward.

Shared decision making takes into account:

- Scientific knowledge and evidence
- Patient autonomy
- Patient value.

It is an essential component of truly patient-centred care. The goal is to arrive at a decision that is "right for me" from a patient's perspective. While many clinicians believe they practice shared decision making, this is not always borne out in practice[9].

Shared decision-making is appropriate for many decisions including those about whether to have a diagnostic test, undergo a surgical procedure or take medication.

The key components of shared decision making are:

1 Developing trust
2 Establishing patient knowledge, expectations, preferences and values
3 Providing information about options, costs, risks and benefits
4 Discussing concerns
5 Checking patient understanding
6 Agreeing and documenting the discussion and decision.

3 Stacey D et al. Decision aids for people facing health treatment or screening options. Cochrane Database Syst Rev 2011; 10: CD001431

4 Coulter A, Collins A. Making shared decision making a reality. No decision about me, without me. London: King's Fund, 2011.

5 Mulley et al. Patient preferences matter: stop the silent misdiagnosis. King's Fund 2012

6 Edwards and Elwyn, Inside the Black Box of Shared Decision Making: Distinguishing Between the Process of Involvement and Who Makes the Decision, Health Expect 9:307-320 (2006).

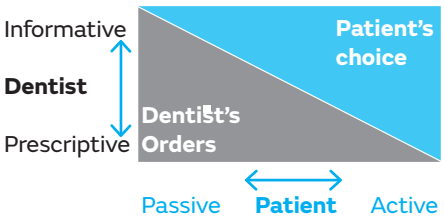
7 GDC. Standards for the Dental Team, 2013

8 NHS. The NHS Constitution, 2013

9 The Health Foundation. Helping people share decision making. London: The Health Foundation. 2012

Figure 2

Preferences – patients and dentists



Benefits of a shared decision making approach

Shared decision making has significant benefits (see below) and should be an integral part of interactions with patients if we are to fully embrace patient-centred care. The initial consultation may take a little longer but less than the time spent dealing with uncertain, unhappy or disappointed patients[4].

Benefits of shared decision making[3, 4, 6, 9, 10]

- Increases patient involvement in the decision making process
- Increased patient knowledge and understanding
- Patients share some responsibility for the decision
- More realistic expectations from treatment
- Decisions and choices that align with patients' preferences and values
- In some cases better health outcomes
- Improves patient satisfaction
- Better adherence to treatment
- Patients are better informed with more accurate risk perceptions
- Helps identify the high risk decision

To develop your skills in shared decision making, book into our Dental Protection *Mastering Consent and Shared Decision Making workshop*.

[10] Scheibler, F., Janssen, C. & Pfaff, H. (2003). 'Shared decision making: an overview of international research literature.' Social and Preventative Medicine, 48:11-23

Protecting information: protecting you

Recent and forthcoming changes to our emails will benefit all members

Dental Protection recognises the significant benefit to members that results from protecting their personal data, as well as the professional and legal responsibility we all have in ensuring the security of all the data we hold and process

We already use an industry standard email encryption solution to help minimise the risk of interception and misuse of confidential and sensitive information. As email security standards and technology advance, we have introduced additional email protection measures from April 2015.

Why have we introduced this change?

"This change is an important step in ensuring we are doing our utmost to protect the security of the data we hold and exchange via email with our members. It demonstrates our on-going commitment to providing the highest level of service and protection for our members."
David Wheeler, General Counsel , Medical Protection Society (MPS)

Will this benefit alter the way I contact you?

The vast majority of our members will not see any difference as a result of these changes and will continue to be able to send and receive emails securely to and from Dental Protection as they do now.

However for some members, depending on their existing email provider and the content of the email correspondence (and any attachments), they may be directed to retrieve and exchange messages with Dental Protection through a secure portal. Some members may already be familiar with using similar portals when uploading or downloading large image files to and from their family and friends.

If you are likely to be affected by this change, we will be writing to you in the coming weeks to provide more information about the changes and how to access the portal. There will also be plenty of information and a helpful guide available on our website to ensure that we make the transition to this new way of handling emails us as simple as possible.

We know that ensuring the security of your own confidential data, and that of your patients and other third parties, is as important to you as it is to Dental Protection. Introducing enhanced email security is part of our on-going commitment to ensuring we continue to put the protection of our member's interests first.

Top tips for email safety

- Choose a secure password (use a combination of upper and lower case letters, numbers and special characters such as @, % and !)
- Use a passcode to lock the screen when not in use on all mobile devices e.g. laptops, mobile phones and tablets
- Change your password regularly and keep it in a safe place
- Don't share your password with anyone
- Remember to log out or sign off from your web email account when you've finished looking at/sending your emails. Simply closing it down is not the same thing.
- Don't open attachments from anyone you don't know
- Don't reply to spam or forward chain emails
- Install antivirus software and keep it up to date

Contacts

You can contact Dental Protection for assistance via the website dentalprotection.org or by using the contacts listed below

Dental Protection

Scheme of co-operation

If your membership with Dental Protection has been arranged through the NZDA scheme you should contact the NZDA as soon as you become aware of any claim, or possible claim, complaint or other need for assistance.

Contact

David Crum via Pepe Davenport, NZDA House,
1/195 Main Highway, Ellerslie, Auckland 1051

Telephone
09 579 8001
Facsimile
09 580 0010
Email
pepe@nzda.org.nz

Membership and subscription enquiries

Jill Watson, Membership, NZDA, PO Box 28084, Auckland,
New Zealand

Telephone
09 579 8001
Facsimile
09 580 0010
Email
jill@nzda.org.nz

Direct members

Should you pay your subscription direct to Dental Protection the contact is:
Dental Protection Ltd, 33 Cavendish Square, London W1G 0PS,
United Kingdom

Telephone
+44 20 7399 1400 (24 hour emergency helpline)
Facsimile
+44 20 7399 1401

Editor
david.croser@dentalprotection.org

October 2015