Ireland

Dental Protection

Riskwise

Risk management from Dental Protection

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Dental implant feature

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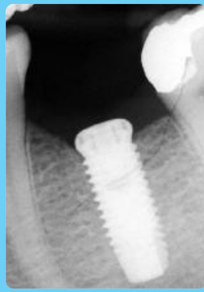
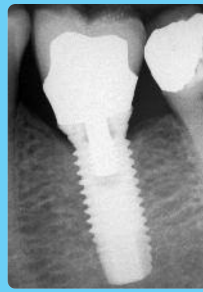
dentalprotection.org





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Editorial

Dr Sue Boynton
Head of Dental Services, Ireland

Welcome to the latest edition of *Riskwise Ireland* which focuses on topics of particular relevance to help practitioners to be safer and more successful in the increasingly challenging environment in which dental professionals practise

I am always grateful to those of you who take the time to come and talk to us at meetings and conferences, and to contact me when you have feedback to provide. Recently I enjoyed meeting many of you at dental events in Galway, Cork, Dublin and Limerick as did my colleague Dr Martin Foster who chatted to many of you at other events in Dublin and Tullow.

The team for you

As you may already know, all of our dentolegal advisers are dentists who understand the challenges you face. Within the wider team we have a dedicated Ireland team which comprises: Dr Susan Willatt, Dr Stephen Henderson, Dr Brian Edlin, Dr Hugh Harvie, Dr James Foster, Dr Martin Foster and Dr Sue Boynton.

Pushing for reform

We continue to work in the best interest of members. We are committed to Ireland and as the leading provider of professional protection we have a unique insight into the challenging environment in which you practise. We understand your concerns about the nature and frequency of clinical negligence claims and we continue to press for tort reform and procedural reform to improve the current claims environment. We have been meeting with policy makers and we await the outcome of the forthcoming election with interest.

You have asked

Some members have asked if seeking advice will result in an increased subscription. You can be assured that we do not, and never have, used the number of telephone calls from members seeking advice as part of its risk assessment of a member. The number of advice calls does not have any impact on the subscription rate that you are asked to pay.

Our approach to risk carefully balances the needs of individual members with those of the whole membership as explained in the article on page 4. Our aim is to identify risk early and to alert members when their risk profile differs from that of their peers. This ensures that we can provide the right support as early as possible to reduce their future risk profile. We are well aware of the potential impact on our member's career if they are deemed a significant risk. Whilst we indicate the nature of our concerns to individual members and try and work with them to reduce their risk, this may not always be possible.

We believe that the interests of the majority of members should not be compromised by a very small minority. Those who have received a comparatively high volume of claims or other matters by comparison to their peers can adversely affect the mutual fund.

Meanwhile, if you have concerns about, or need help dealing with a complaint, please contact us for advice to provide peace of mind and to help prevent your concern or problem escalating.

Easier to contact us

We understand that some members would like to speak to us outside our normal office hours of 8.30am to 5.30pm. As well as calling in these hours you can also book a callback so that one of our team of dentolegal advisers will call you back at a time convenient for you. Callbacks are available from 8.30am to 7pm Monday to Friday. Simply call 01280 8668 during normal hours to book your callback.

CPD

The Dental Council's new CPD requirements establish the clear ethical obligation for all registrants to maintain their knowledge and skills. This means not only completing CPD, but also keeping appropriate records of all CPD undertaken.

Dental Protection provides RiskCredits for risk management CPD where the event has been organised by Dental Protection or where Dental Protection has provided a speaker. You may wish to take a look at our website for more information. Look out for the RiskCredits submission form which is included with your renewal documents each year. It is well worth taking a moment to complete and submit it, as we recognise that improving your risk management makes you safer in practice and we provide you with a discounted subscription.

- Relationship management,
- Conflict resolution and
- Complaints handling.

These topics form part of the Dental Council's recommended Core CPD subject matter. Dental Protection's Risk Management workshops assist practitioners in gaining skills in these key areas. Look under the events tab in the Ireland pages on our website for more details.

You can also log into our eLearning Hub Prism dentalprotection.org/prism at any time and learn at a time and a place that suits you.

Dental Advisory Panel

We are privileged to have such an inspiring group of dentists on the panel which provides Dental Protection with input and advice regarding the challenges facing members in Ireland. These colleagues work hard to collect views from the dental profession in Ireland and convey them to us with positive suggestions. You'll see from the article written by Dr Jane Renehan, just how influential and beneficial their contribution can be.

I hope you find this edition of *Riskwise Ireland* helpful. As ever I look forward to receiving your comments and feedback.

Best wishes

Dr Sue Boynton
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Listening to our members

We know that concerns have been expressed in Ireland regarding how we work with dental members whose risk profiles differ significantly to that of their peers. We felt that it would be helpful to explain our approach to risk and dispel some of the myths that have arisen

In search of fairness – striking the balance

Dental professionals are more likely to face a complaint or claim during their career than was the case 10 or 15 years ago. But some practitioners will experience a higher number of incidents than their colleagues working in the same area of practice. We try to understand any underlying reason(s) for these differences and to take an approach which carefully balances the needs of the individual member with those of the membership as a whole.

We all collectively own this mutual organisation (which operates on a not-for-profit basis). But in Ireland where the rising cost of professional protection has been particularly unwelcome through difficult economic times, it is not reasonable for the majority of members to be effectively subsidising other colleagues who have received a comparatively high volume of claims or incidents. A typical member who has few (or no) cases will often ask us why their subscriptions keep going up. A balance needs to be struck to achieve the most equitable outcome for everyone. In addition, by partnering with members through advice and education we can help support an individual to improve their risk profile.

Where a member's risk profile differs significantly from that of their peers, we may consider raising their membership subscription in line with their risk or signposting them to our educational resources. We may make participation in certain education and risk management activities, a condition of continued membership – and we believe that most members would understand and support this. Only in rare and exceptional cases, where a member's incident history and/or risk profile is far outside the norm of their peers, will we consider terminating or declining to renew membership. We are of course assessing future risk, using past experience as a guide but also taking into account other mitigating factors.

Recognising the potential impact that such a decision could have, it is not one that is taken lightly. As you would expect, we continually refine our processes, and we are extending the timing of key stages in the assessment process, inviting the comments from the members concerned at an early stage, before any final decision is made.

It's a fact

Calls to our telephone advisory helpline or requests for written advice which do not lead to case handling or (for example) claims or legal costs, are not factors in our assessment of risk, so nobody is ever penalised just for having called us to seek advice.

Some members have asked if seeking advice will result in an increased subscription. You can be assured that we do not, and never have, used the number of telephone calls from members seeking advice as part of our risk assessment of a member. The number of advice calls does not have any impact on the subscription rate that you are asked to pay.

It's a fact

Having claims brought against you won't necessarily mean that we consider you have a heightened risk profile either. Our focus is purely on those members whose risk profile sits far outside that of their peers. Even then our first instinct is to work with the member to reduce their risk.

In perspective

You may be reassured to learn that only a very small number of members in Ireland (less than half of 1% of the total membership in Ireland) have been assessed to have a non-standard risk profile. Members can discuss their individual risk profile with members of the Risk Department Underwriting Team should they wish to do so. This team play a pivotal role in identifying members whose risk profile is unusually high and working with them, through education, to reduce it. Such partnerships have proven successful in the past and we are proud that this approach lies at the heart of the protection that we provide.

In my view

Dr Jane Renehan shares her personal thoughts about improving our service to members

Dr Jane Renehan is Chair of the Dental Advisory Panel (DAP)

Recent years have been challenging for the dental professional. The last decade has brought many changes to dentistry. All elements of Irish society were to a greater or lesser extent affected by the economic downturn, however dental practice had to withstand the burden of an environment impacted by cuts in government spending alongside the simultaneous shift to a consumer-based economy. I am not optimistic for our future. I believe this era of change will endure and continue to impact significantly on how we deliver care to our patients

Along with the Dental Advisory Panel (DAP) in Ireland, Dental Protection maintains advisory panels in other countries where it serves members. These advisory panels provide local information, frontline advice and an update about emerging issues. Such an organisational model needs a robust governance structure at its centre if it is to demonstrate best practice in today's business world.

Following the inaugural meeting of the DAP for Ireland in 2013, I was honoured to be elected as Chair. DAP committee membership comprises clinicians who reflect a variation in dental practice backgrounds and by Dental Protection staff from the Ireland Dental Services team.

Dental Protection has actively sought our input on matters such as Risk Credits, Horizons Ireland, *Riskwise*, website improvements, and an improved standard of communications across the wider membership. From the beginning Dental Protection directed us to find our own focus. By setting our own agenda we can determine what items are discussed at meetings.

As Chair

I introduced a standing agenda item of "Current and Emerging Issues". This is the opportunity for committee members to raise issues considered relevant (either directly or indirectly) to Dental Protection. It tends to be the liveliest part of each meeting and for me a fascinating item to chair. Exchanges are often energetic and vigorous but always with the general membership's needs to the forefront. During these debates I frequently recall an eminent Dublin Dental Hospital Professor extoling the virtues of "*Local Knowledge and Native Cunning...*" His words still hold great wisdom today!

The topics discussed cover the spectrum of dental practice, ranging from potential changes to the Dentists Act (1985), the Dental Council Code of Practice on Infection Prevention and Control, to the cost of membership.

Risk Credits

This topic has occupied much conversation. Did you know that Ireland is the only country where the Risk Credit Scheme operates? Understandably it had some inaugural difficulties. I am very pleased to put on record that, without fail, Dental Protection has fully accepted that the Scheme needs further administrative tweaking and is currently working with the committee to address these problems.

Committee members totally endorse the fundamental aims of the Risk Credit Scheme; rewarding those who participate but more importantly building within the profession a capacity to significantly reduce clinical risk to our patients.

I really appreciate that committee members have displayed their commitment by giving of their personal time to attend meetings and to prepare in advance by actively engaging with colleagues across the country. I have had the satisfaction of watching the fledgling advisory panel first finding its feet and now reaching the stage where it can go from strength to strength.

Do they listen?

In my opinion, Dental Protection most definitely listens to the DAP. The Ireland team under Sue Boynton has now aligned more closely with the Irish market place. I firmly believe there is a heightened appreciation that dentistry in Ireland is unique and self-defined. As such it can't be taken for granted and regarded as an extension of what is happening in other jurisdictions. I have seen at first-hand how Dental Protection staff have adapted to the new economic reality in our land and are rising to meet its challenge. It must also be acknowledged that all of this is happening at a time when Dental Protection itself has seen an unprecedented increase in the number of claims it is handling.

In my view

The next step

The wider membership will start to experience the benefit of the input from the DAP when dealing with Dental Protection. Small but significant changes have already filtered through. Kevin Lewis's Director's Report (April 2015) to the DAP advised that the views of the panel are invaluable to Dental Protection and it is important that this initiative maintains its momentum.

Kevin acknowledged that since the first DAP meeting Dental Protection has:

- Developed the digital newsletter NewsMatters. This has a 52% open rate (an industry average is 20-30%). Update your contact details with Dental Protection if you are not receiving this service.
- Developed a new format for Horizons with local speakers and more Ireland cases.
- Created more Ireland-specific content in *Riskwise.*
- Developed a new website – with more content for the Ireland section eg. FAQs, Continuum, PRISM.
- Increased its profile in the dental press.

I invite you to contact the Dental Advisory Panel, to raise any issue which you believe could be reviewed by DAP.

If you have a suggestion, want to comment or send feedback marked for the attention of the Dental Advisory Panel using any of contact details onthe back page.

I look forward to hearing from you.

The Dental Advisory Panel

Dr Jane Renehan (Chair)
Dr Martin Holohan
Dr PJ Byrne
Dr Ryan Hennessy
Prof Stephen Flint
Prof Gerry Kearns
Dr Garry Heavey
Ms Susan Johnson

Left to right seated; Dr Gary Heavey, Professor John Gibson (Chair of Dental Protection Limited), Dr Jane Renehan, Dr Kevin Lewis, Professor Stephen Flint. Standing; Dr P J Byrne, Dr Sue Boynton, Dr Ryan Hennessy, Ms Sue Johnston, Dr Martin Holohan. Absent; Professor Gerry Kearns

Team communication

Dr Ryan Hennessey describes the value that comes from effective communication with the hygienist in your team

Dr Ryan Hennessey is a GDP and a member of our Dental Advisory Panel

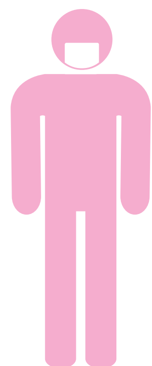
Our practice has had the good fortune to add a hygienist to the team, and over the past 18 months the appointment book has grown. The hygienist has at last become an integral part of our practice

Convergence

Hygienists, like associates, are entrusted with the responsibility of caring for our patients. There is the potential for misunderstanding if the hygienist and the dentist do not work with the same protocols and goals in mind. That's why effective communication is so important.

Dentists spend their days dealing in millimetres and fine margins and can become very focused on minute clinical detail. Unfortunately, the skill-set required for this type of work does not necessarily include communication skills. For this reason, dentists need to be aware that if work is delegated to another team member, appropriate communication is necessary to ensure the treatment goals are achieved.

Not only communication between the dentist and the hygienist but also communication with the patient so that he or she understands the benefits of the team approach as well as who will be doing "what" and "why". It's not "just a wee polish" as some refer to it.



Chronic problems

Dentistry does not operate in an ideal world and in the middle of a busy day, clinical notes are sometimes delayed or abbreviated; periodontal status may get mentioned and deferred to a later appointment if the patient presents with something more urgent. Dentists are sometimes so busy dealing with acute problems that the treatment of chronic issues can seem less important.

Unfortunately, the incidence of chronic periodontal disease remains high worldwide, with severe periodontal disease, which may result in tooth loss, found in 15–20% of middle-aged (35-44 years) adults (WHO).

The level of periodontal disease in the Irish population has not been measured since the last national oral health study[1] which found a high level of periodontal disease and attachment loss in the Irish population,

Patient awareness

Patients are also not always aware of, or are in denial about periodontal issues and they can be reluctant to seek treatment. "If it's not broken don't fix it" unfortunately is not an effective approach to periodontal care.

Good communication between the dentist and the hygienists is essential if patients are to navigate the continuum from periodontal disease to periodontal health and maintenance. Only by regularly monitoring and recording periodontal indices can the transition be documented. Sharing these details from the clinical records serves as an excellent motivational tool for the patient.

Protocols

Practices need to have agreed systems in place to ensure patients receive early diagnosis and management of any periodontal disease. A series of protocols can be developed by the dentist as team leader or by the dentist in conjunction with the hygienist, as in my practice.

Once agreed, the individual protocols provide a framework for communicating the treatment plan and the patient's progress. The framework would normally include a diagnostic protocol, a periodontal care programme, a prevention and maintenance programme with defined recall times and a mechanism for review. There also needs to be an effective method of communication within the dental team for the discussion of more complex cases.

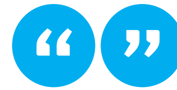
Different methods

Hygienists regularly work in more than one practice. This means that they may come across different approaches to patient care.

Hygienists should be encouraged to ask for an explanation of the dentist's treatment plan if it is not clear or to highlight any issues of concern to avoid confusion and ensure they understand their role for the care of individual patients. Such an approach also serves as a quality control mechanism for the standard of care being provided.

Good communication is essential if patients are to navigate the continuum from disease to health

Team communication



A defined list of individual responsibilities helps create a consistent approach

Communicating with reception

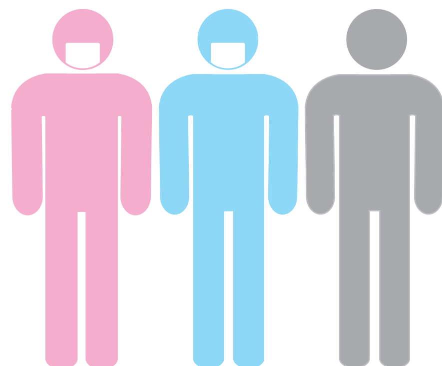
The hygienist is partially responsible for ensuring that the patient is booked for their regular recall and understands the reason for recall appointments. It's all part of the team approach and a patient needs to understand that they are also part of the team! After all the periodontal condition is their problem and the patient needs to recognise their own responsibilities for this aspect of their oral health. Both the dentist and the hygienist have an important role in bringing the patient to that understanding.

A common understanding about treatment together with a defined list of responsibilities helps to create a consistent approach to periodontal care within the practice.

It is important that the entire team should be familiar with the roles of the dentist and the hygienist.

Problems can arise when everyone assumes that someone else is providing a certain element of oral care, and that element gets overlooked, for example monitoring of pocket depths.

An annual audit of completed treatments can be a valuable tool to demonstrate how effective your practice is in treating periodontal issues and providing preventative treatments.



My own practice

In my practice, if a patient has been found to have active periodontal disease, they are informed and then rebooked for a full periodontal assessment by the dentist. This will include a full periodontal charting and panoramic radiograph.

At this visit, the patient is educated about the disease and where it manifests in their own mouth. We show patients their radiographs on screen, and also a graphic representation of their attachment levels using our dental software.

We have found this to be an important pre-treatment stage, and having discussed the implications and treatment options, patients who understand the process are much more likely to commit to treatment. Once a course of treatment has been agreed, the patient is then rescheduled to the hygienist for a number of visits.

Team approach

The dentist records the agreed treatment plan in the notes for the hygienist. The hygienist and dentist will discuss the treatment plan prior to treatment, giving the dentist a chance to highlight problem areas.

Once the agreed plan is complete the patient is rebooked for review to the dentist after a three-week period. At this visit, any further treatment need is evaluated, options are discussed and agreed where necessary and hygiene recall dates are set.

During the year, the dentist and hygienist meet periodically to discuss how the care programme is working and to assess any potential issues.

We regularly review cases to provide feedback between the dentist and hygienist and also to assess any referral responses from periodontal specialists that have been involved.

A number of periodontists employ their own hygienists, so if you have your own hygiene team you should inform them of this in the referral so that their treatment recommendations can be carried out in your own practice.

Patients are sometimes confused about the interface between the care provided by us and the specialist, and in particular about the range of treatment that you can offer in house. Take a moment to check that their understanding is complete.

Successful treatment depends on good communication.

Reference

[1] Oral Health of Irish Adults 2000 – 2002 Department of Health. http://health.gov.ie/wp-content/uploads/2014/03/oral_health02.pdf

The minefield of implant dentistry

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

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 worrying recent claims statistics arising from implant dentistry

We are grateful to Nobel Biocare for the use of the images on pages 9–14

The minefield of implant dentistry

At every renewal, it is a member's personal reponsibility to check that the category and rate they are paying is still correct

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 would not make sense to become involved in implant dentistry with relatively little formal, structured training and mentoring.

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. Were such a dentist, with relatively little (narrow) experience of clinical dentistry to undertake a complex restorative case which then goes wrong, this could be referred to a Dental Council hearing with all the attendant consequences. 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 the course of a negligence claim, or before the Dental Council) 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.

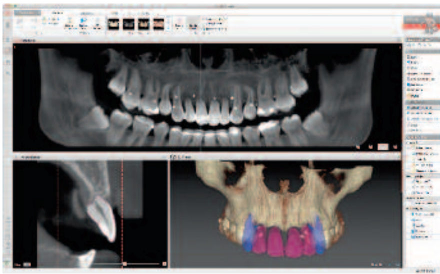
The tools for the job

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

As extraordinary as it might sound, there are still practitioners getting involved in implant dentistry without having protected themselves (and indirectly, their patients) with any kind of professional indemnity arrangements. Other practitioners sometimes overlook their membership renewal date, or decide to save money by choosing an inappropriate membership category that does not fully reflect the extent of their clinical practice, or even by allowing their membership to lapse.

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 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.



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

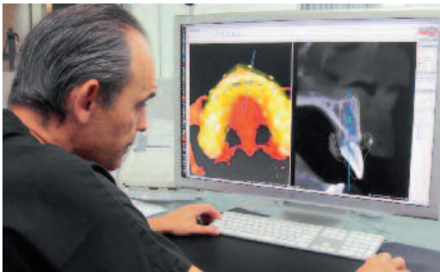
Getting started

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.

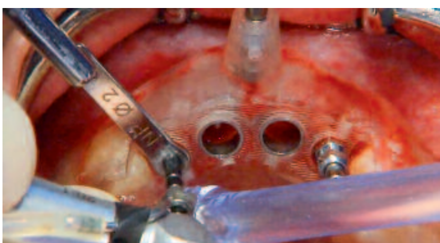
Mentoring

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



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. 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).

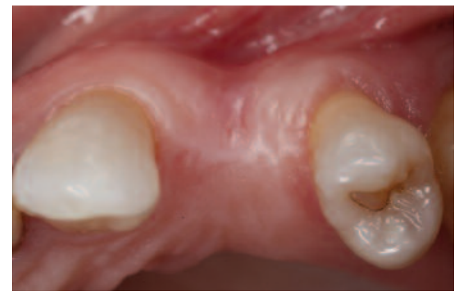
Nowhere is the need for this "seamless" approach more obvious than in the consent process; a patient needs to understand all material facts that relate to the surgical placement of the fixtures, and also to whatever appliance or restoration the fixtures will be supporting. A material fact is one that a patient would be likely to attach significance to, when considering whether or not to undertake the procedure. (see page 20)

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 Radiological Institute of Ireland Regulations*, 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:

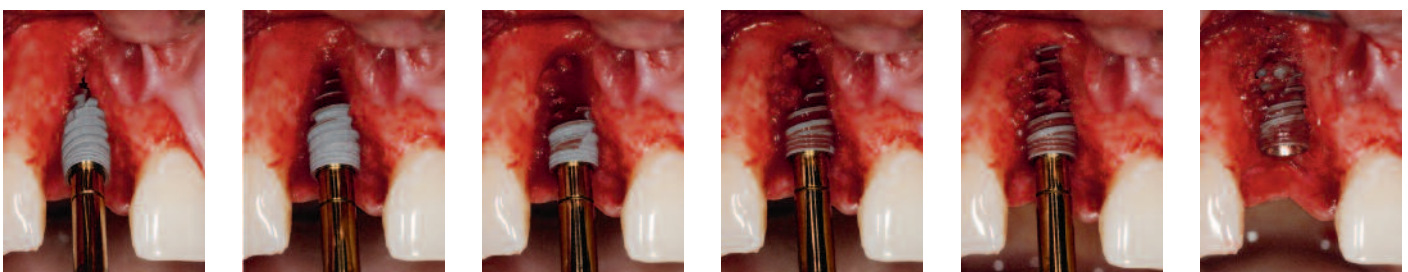
a the additional imaging was (or was not) necessary in the circumstances of the specific case,

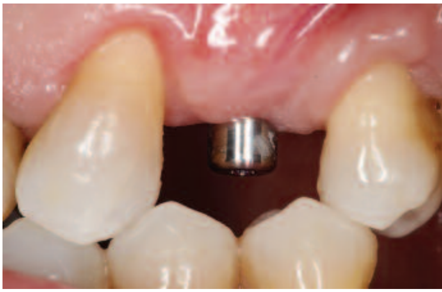
b a responsible clinician acting in the patient's best interests would proceed with placing the implants without the additional imaging being available.

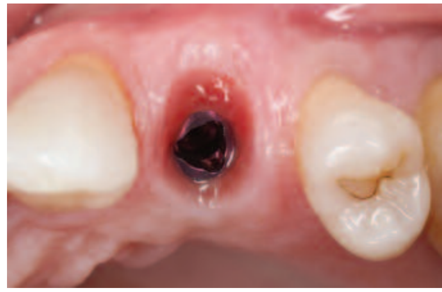
Another example of a step which improves predictability and reduces uncertainty (especially in an edentulous arch) is the use of stents and other forms of surgical guides where appropriate, and in more complex cases, the construction and use of surgical models.

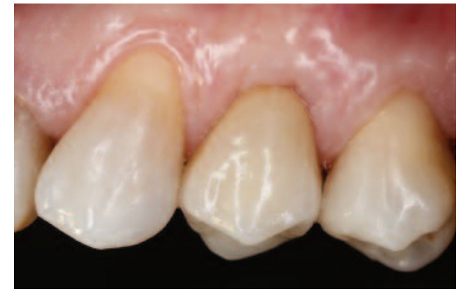
Spend time validating consent

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?
- 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, that the patient needs to understand before proceeding. Some patients may object to 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?

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

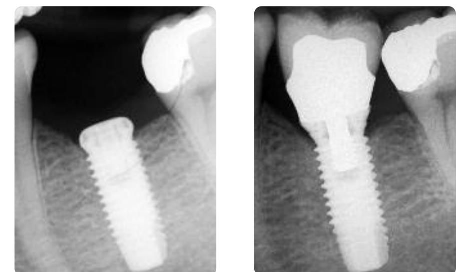
Take appropriate steps to recover the situation which in some cases may involve referring the patient for specialist advice and care.

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

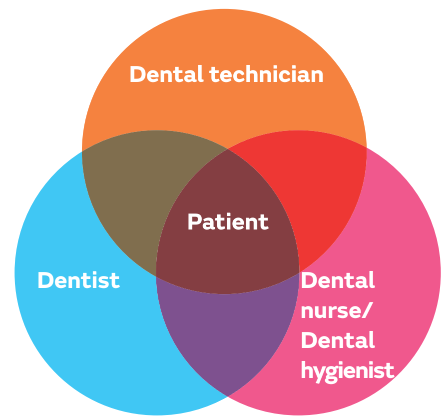
Choose appropriate intervals following the procedure and especially in the days immediately following the placement of the implant(s)



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

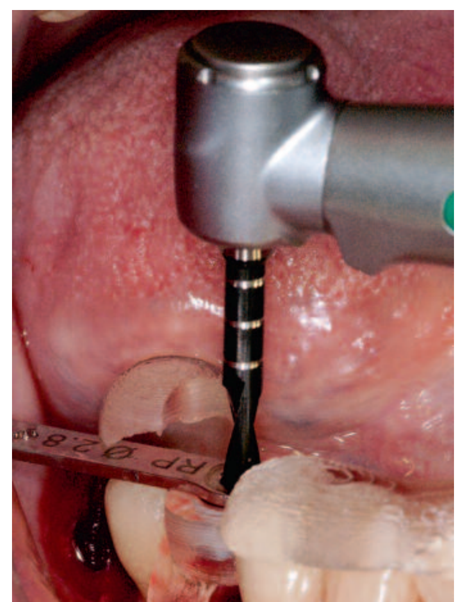
In implant dentistry, every stage of the process needs to be very carefully recorded. Especially important here are records of what the patient was led to expect, what information was provided to the patient, what warnings they were given etc.

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 meticulous 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

Dr Martin Foster is one of the Dentolegal Advisers supporting members in Ireland

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
www.quit.ie
www.cancer.ie
www.nice.org.uk/guidance/ph10

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.

Accordingly, I encourage your attendance at an update course on medicine and oral medicine. Perhaps, also, you might consider investing in one of the excellent textbooks on the same subject matter for your practice or office. Try working through each chapter with your team as a week-by-week seminar or tutorial series, updating yourself and those with whom you work.

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.

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John is Professor of Medicine in Relation to Dentistry and Honorary Consultant in Oral Medicine, University of Glasgow Dental School & NHS Greater Glasgow & Clyde.

He has published extensively in his own right and as a co-author not only in his specialist field of oral medicine, but also across a wide range of topics in the field of professionalism and the impact on multiculturalism in healthcare.

John is Chair of the Board of Dental Protection.

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).

Although there are no similar guidelines in Ireland it may be worthwhile visiting 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.

It is always thought-provoking when "tried and tested" advice is challenged

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 Gynaecologists) 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*".

This advice has been incorporated into the British National Formulary (UK) There is now no need for dentists to issue instructions on additional methods of contraception to patients on (or being prescribed) antibiotics unless the patient is having diarrhoea or vomiting. In these circumstances, advice may be sought from the patient's GP.

In the medicine cabinet

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.

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Sleep apnoea can have both local (muscular) and systemic origins

Probity

The importance of declining an inappropriate request

Many patients pay into schemes which cover the cost of dental care. The details of the schemes vary. Some cover only a certain type of treatment whereas others have a qualifying period during which no treatment can be claimed. Generally the patient pays the cost up front to the dentist at the time of the treatment and reclaims it by submitting receipts to the scheme

Each scheme will commission its own probity checks to ensure the veracity of the claims being made. Of course the onus is on the patient to make an appropriate claim. Whilst most patients claim truthfully, there have been occasions when a patient has asked a dentist to provide an inappropriate receipt – perhaps in someone else's name, or for a different treatment, or for treatment not provided, or for treatment provided at a different time.

Whilst a patient can be quite persuasive in making such a request, the dentist needs to be quite clear to the patient that their request will not be entertained. It is not uncommon for probity checks to be performed with records being requested, sometimes along with verification from the patient. Patients may see things more simply and may not understand the implications for the dentist and the fact that they are wrong to make such a request.

Any dentist who provides an inappropriate receipt (eg. falsifying either treatment details, dates or names) is putting not only his or her professional reputation at risk, but also, potentially, his or her registration. The dentist may also be at risk of a criminal prosecution and such a prosecution could then lead to action from the Dental Council. Unfair though it may seem, the dentist can actually find himself or herself in much more trouble than the patient.

As healthcare professionals we may be sympathetic to a patient who cannot afford their dental care. However, every dentist also has a professional duty to act ethically and responsibly.

Falsification of the details on the patient's receipt for their treatment can put your registration at risk

Scenario

A patient, who had not been to the dentist for a number of years, attends for a check-up. She had neglected her teeth and needed a large number of fillings. On reviewing her treatment plan and the associated fees she advised the dentist that she could not afford the proposed treatment - a not uncommon situation.

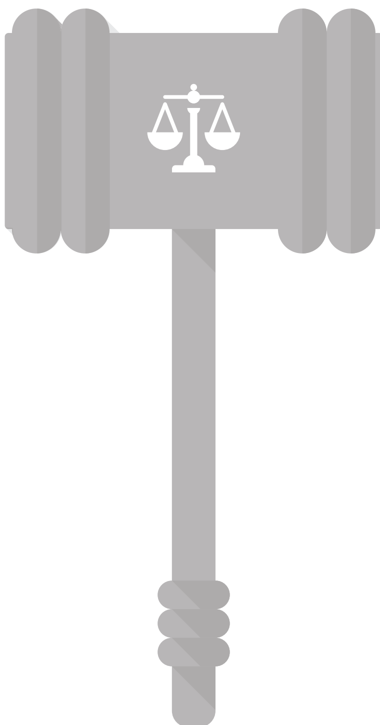
The dental nurse suggested that the patient might join a scheme then return for her fillings after that scheme's three month qualifying period. The patient thought this was a good idea, but wanted to have her dental treatment completed within a short period of time before her holiday. She applied pressure to have her treatment completed during a two-week period in January, but wanted a receipt indicating that the treatment was carried out in April. She implied that friends had claimed for dental treatment in this way and it was "common practice".

Although sympathetic to the patient's dilemma, the dentist was unequivocal in his response. He explained that he had a professional duty to act ethically and provide a receipt which was factually correct. He could not support the patient's intention to deceive the scheme. The dentist stood his ground in the face of the patient's insistence that she would only be able to have her treatment at the practice if a post-dated receipt was provided.

Once she realised that the dentist would not act inappropriately, the patient left to seek dental care elsewhere. If she adopted a similar tactic at your practice- what would your response be?

UK courts redefine consent

Following a recent landmark decision in the matter of *Montgomery v Lanarkshire Health Board* (11 March 2015), Alison Kelleher and Sharon McCauley highlight the implications for healthcare professionals



The case

Mrs Montgomery was expecting her first baby. She was of small stature and suffered from insulin dependent diabetes mellitus, which increases the risk of excessive birth weight and the risk of shoulder dystocia by 9-10%. As a result of the elevated risk, she was regularly monitored intensively during pregnancy.

Mrs Montgomery delivered her baby in what was described as very stressful circumstances. The birth was complicated by shoulder dystocia. Medical staff performed the appropriate manoeuvres to release the baby but, during the 12-minute delay, he was deprived of oxygen and subsequently diagnosed with cerebral palsy.

Mrs Montgomery's case was that if she had been advised of the risks of vaginal delivery appropriately and fully, she would have opted for an elective caesarean section and her son would have been delivered undamaged.

Mrs Montgomery brought a claim against Lanarkshire Health Board, alleging that she should have been advised of the 9-10% risk of shoulder dystocia associated with vaginal delivery, notwithstanding the fact that the risk of a grave outcome was small (less than 0.1% risk of cerebral palsy).

Lanarkshire Health Board argued that only the risk of a grave adverse outcome triggered the duty to warn of such risks and that, because the risk of such an outcome was so low and that an expression of concern was not the same as a direct question requiring a direct answer, no warning was required.

Evidence was heard that, during the course of her ante-natal care, Mrs Montgomery had raised concerns about giving birth vaginally. During the course of the trial, Mrs Montgomery's consultant (C) gave evidence that it was her policy not to routinely advise diabetic women about the risk of shoulder dystocia and hypoxia as she perceived the risk of those problems arising to be so small. Her view was that if the risk of shoulder dystocia was explained, patients would opt for a caesarean section, which in her opinion, was not in the mother's interest.

Ciarán O'Rorke is Head of the Healthcare team at Hayes solicitors, one of Dental Protection's panel of law firms supporting dental members in Ireland

The clinician's advice has to be "sensitive to the characteristics of the patient"

Judgment

The Supreme Court held that the question should have been about Mrs Montgomery's likely reaction if told of the risk of shoulder dystocia. The unequivocal position was that she would have chosen to give birth by caesarean section.

The Bolam test (a test used in the UK similar to the Dunne test) was deemed unsuitable for cases regarding the discussion of risks with patients, as the extent to which a doctor may be inclined to discuss risks with patients is not determined by medical learning or experience. The court ruled that Mrs Montgomery should have been informed of the risk of shoulder dystocia and given the option of a caesarean section. Mrs Montgomery was awarded £5.25 million in damages.

A seven-judge Supreme Court held that C should have explained the risks of shoulder dystocia vaginal delivery to Mrs Montgomery. The court found that: The assessment of risk to a patient cannot be reduced to percentages and the assessment of a risk is both fact-sensitive and also sensitive to the characteristics of the particular patient. The doctor's role involves dialogue, the aim of which is to ensure that the patient understands the seriousness of the condition, the anticipated benefits and risks of the proposed treatment and any reasonable alternatives so that she is in a position to make an informed decision.

The patient should be able to make the decision whether to undergo a proposed course of treatment, making an informed choice even where she is liable to make a choice which a doctor considers to be contrary to her best interests. Significant weight was placed on C's evidence that she didn't warn of the risks because, if she did, every expectant mother would opt for an elective section and that Mrs Montgomery should have been offered an elective section. Based on this evidence, it was found that Mrs Montgomery should have been warned of the risks and that, if she had, she would not have attempted a vaginal delivery.

Consent and understanding

The Irish Supreme Court case of Fitzpatrick v White (2007) confirms the High Court judgment of Geoghegan v Harris (2000) and states that the consent must be voluntary, must involve the requisite mental capacity and must be informed. The material risks must be disclosed. When considering what a material risk is, the clinician must consider the statistical frequency of the risk and the severity of the consequences.

The risk may be seen as material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it. The court will then apply a subjective test and consider whether, if the appropriate warnings were given, the patient would have proceeded with the treatment.

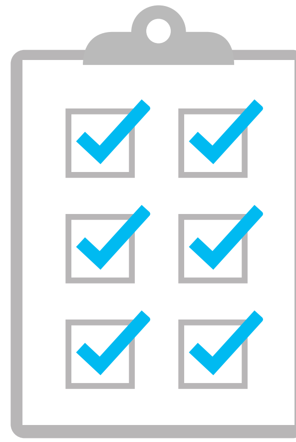
This can be contrasted with Mrs Montgomery's case where the UK Supreme Court goes further than the current Irish Law in relation to consent. In Mrs Montgomery's case, the court stated that to enable a patient to make an informed decision, the clinician must have a conversation with the patient to "ensure that the patient understands the seriousness of her condition, and the anticipated benefits and risks of the proposed treatment and any reasonable alternatives, so that she is then in a position to make an informed decision".

The clinician's advice has to be "sensitive to the characteristics of the patient". It was further emphasised that the clinician's obligation will only be discharged if the information is explainedin a way the patient understands.

The clear message from the UK Supreme Court is that the wishes of the competent patient are paramount, even when they conflict with what the doctor considers, even correctly, to be in the best interests of the patient. Reassuringly, Dental Protection's advice has reflected the new position for over 20 years.

This sits alongside the view of the Dental Council published in their Code of Professional Behaviour and Ethical Conduct which states:
You have a duty to explain to your patients the range of treatment options available and the risks associated with each option. You must give your patients enough information, in language they understand, so they can make informed decisions about their care.

Personal development plans



If the safe delivery of health care to patients is to be assured, there is an expectation upon a professional to take responsibility for his or her own professional education, to update it regularly and to have documented evidence of this. Lifelong learning is one of the markers of a true professional

CPD learning and self- assessment

In the early stages of professional education, the learning curve can be steep but it is normally well supported by university lecturers and other academics in a structured teaching environment. The process is formal, heavily supervised and monitored, with feedback on performance and results that is informed, reliable and, above all, continuous. Once qualified, there is an expectation upon a clinician to continue updating and furthering his or her knowledge through a wide range of education platforms with the onus on the clinician to continue to learn and develop throughout a potentially long and challenging career. Dentistry provides many opportunities to learn and develop on a day-to-day basis.

The Dental Council's CPD requirements[1] set out the Dental Council's revised minimum requirements for CPD. Although CPD is not yet mandatory it is likely that a statutory CPD scheme be introduced in future legislation. At present registrants have a clear ethical obligation to maintain knowledge and skills: *You must keep your professional knowledge and skills up-to-date and undertake continuing professional development (CPD)*

The Dental Council recommends that dental practitioners complete, and keep records of, at least 50 hours of CPD every year. Twenty of these hours should be 'verifiable' CPD. Generally, only activities approved in advance by the Dental Council can be regarded as verifiable CPD.

The amount of CPD hours completed may vary from year to year; you should complete at least 250 hours of CPD every five years, of which a minimum of 100 hours should be verifiable CPD.

It is recommended that your core CPD activities should take a minimum of 50 verifiable hours over a five-year period.

Lifelong learning is not just about going on courses

Recommended core CPD subjects

Subject	Hours
▪ Infection prevention and control	10 hours
▪ Radiology informatics and radiation protection	5 hours
▪ Professional communication including:- Ethical and legal issues - Handling of complaints - Conflict resolution - Relationship management	10 hours
▪ Medical emergencies	5 hours
▪ Audit	7 hours
▪ Record keeping	5 hours
▪ Governance	8 hours

Verifiable CPD means the activity must provide

- Concise educational aims and objectives
- Clear anticipated outcomes
- Quality controls eg the opportunity to provide feedback
- Documentary proof of attendance evidence.

So how should a clinician choose what CPD to do? Lifelong learning is not just about going on courses; there's a real danger of 'ticking the boxes' by choosing courses or reading articles that simply reinforce what we already know. Updating clinical skills and embracing a broader knowledge of dentistry minimises the risk of being exposed to any potential criticism.

Investment in CPD is an investment in one's own professional development. As this requires both time and money it is important to plan how to target that investment so as to gain best value from it.

CPD might include:

- Online eLearning modules
- Journal reading and private study
- Training courses and seminars
- Staff training
- Private study
- Peer group meetings

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What is a Personal Development Plan?

A Personal Development Plan (PDP) is a dynamic tool that can identify areas for further development and encourage lifelong learning. A PDP can identify goals for the future and methods for achieving these goals. PDPs have been advocated as a basis for continuing professional development (CPD). A PDP will change as goals are met and new priorities are recognised.

It takes motivation to take the first steps to create your PDP. It is often easier to start the process by discussing it with a colleague or a mentor. Of course you can work on your own, and you may prefer that, but supporting each other in the creation and implementation of a PDP provides powerful evidence of the intention to act in our patients' best interests.

The three steps of a PDP should perhaps be regarded as a cycle of events:

- Planning
- Execution
- Reflection

Questions you may wish to include:

- What development needs do I have?
- How will I address them?
- Date by which I plan to achieve the development goal
- Outcome. *How will my practice change as a result of the development activities?*
- Completed. *Confirmation that the development need has been met.*

What are the aims of a PDP?

A PDP is a foundation on which to develop a philosophy and maintain high levels of professionalism and clinical skills throughout the team. A PDP should help direct learning and be used as a template for professional development that demonstrates the whole practice team is committed to high standards and good clinical practice. To simplify things, the targets you set yourself in your PDP should be **SMART**

- **S**pecific
- **M**easurable
- **A**chievable
- **R**ealistic
- **T**imed

Reflective logs

A reflective log is a way of thinking in a critical and analytical way about your work in progress. Self-evaluation is a key part of learning and keeping written reflective logs each time you undertake personal development is an essential part of your personal development activity. There is no standard format for a reflective log and there are many templates available. Genuinely identifying development needs means a clinician must be focused, courageous, honest and structured when reflecting on performance. Recognising and admitting when something has not gone well is extremely uncomfortable. On the other hand, it can provide useful pointers for a PDP. The inclination to offer new services to patients should also prompt the need for candid reflection about which skills we will need to do that safely and successfully.

Conclusion

A developing career needs careful planning, so it is important to have a framework for ongoing learning. A business plan may be developed in tandem for all-round support and cohesion. Being committed to a well thought-out and well-designed PDP will give stability and structure to your on-going professional development.

Some practitioners find it helpful to identify a mentor to support them in their learning journey. Equally, some find it professionally satisfying to mentor others and to encourage a safe and supportive clinical and business environment in which a whole dental team will flourish both professionally and personally.

Making time to reflect individually or with others on what you have learned, what you will do the same or differently as a result and whether your on-going learning needs have changed is essential for developing a team of confident, safe and competent dental professionals all working to the best of their abilities within their Scope of Practice.

A PDP will help you to decide in advance what CPD can most effectively advance your professional development.

Keeping skills and knowledge up to date throughout a career is at the heart of what it means to be a dental professional.

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FSC logo (12 x 26mm) to be placed. Please note cyan keyline for size only (do not print)
FSC logo to print in black