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www.dentalprotection.org
As we reach the midpoint of 2015, it is timely that we should pause to reflect upon whether or not UK dentistry is in a better or worse position than at the equivalent moment in 2013 or 2014. So much happened in 2014, particularly - but not solely - in relation to the GDC, that it felt almost as if the profession was in some kind of free-fall.

**LASPO**

A year earlier, in 2013, the long-awaited LASPO reforms to the costs arrangements in clinical negligence and other personal injury claims were brought into effect. Two years later, we have come to realise just how much stockpiling of pre-LASPO claims the “now in-no fee” lawyers had been doing, so that they could continue to take advantage of those much more generous fee and costs arrangements from which they had benefitted for well over a decade.

Only now are we starting to glimpse the true picture of life as it might be in the new post-LASPO environment with the announcement by the Health Minister (Ben Gummer, 25 June 2015) of the government’s intention to cap excessive legal fees in clinical negligence cases.

**New Government**

Following the recent General Election here in the UK, we share the disappointment of both the GMC and GDC that the recent Queen’s Speech did not include any plans to reform professional regulation arrangements in healthcare by implementing the changes that had been proposed in the Law Commission Bill. While we did not agree with all of the changes proposed in that Bill, we would certainly welcome many of them because of their potential to produce dramatic improvements in procedure and process, fairness and proportionality of approach. This has obvious benefits for our members but also (less obviously perhaps) for patients.

We are hopeful on behalf of our UK membership that all interested parties can bring pressure to bear upon the new government to include these and hopefully other important reforms in its legislative programme for the 2016/2017 session. We will play our part in that, without diminishing in any way the efforts we have already made to challenge and contain the many problems besetting the GDC’s existing Fitness to Practise procedures (more information provided later in this publication).

**You have asked**

The past nine months have been an extremely frustrating period on both the litigation and regulatory (GDC) front and the spiralling cost of protecting members against these two threats has given us no room for manoeuvre when setting subscriptions. Many members have expressed their concern at the subscription increases of recent years, and I therefore thought it right that several pages of this expanded issue of Riskwise UK should be dedicated to explaining some of the factors that have contributed to keeping subscription levels for UK dentists (outside Scotland) at levels much higher than any of us would wish.

I say “outside Scotland” because the “no win-no fee” law firms do not operate there to any great degree and this has resulted in subscriptions for the majority of our Scottish members remaining at virtually the same level since 2007, now less than a third of the subscriptions for a member south of the border.

This startling fact may offer little comfort to members outside Scotland but I hope it serves to emphasise the point that we charge no more and no less than the amount we believe, on expert actuarial advice, that we need to collect in order to protect our members not only in the year ahead, but for as many years into the future as you, and they, require our assistance. That meticulous fairness explains the difference in our subscriptions between Scotland and the rest of the UK.

Never forget that this is a mutual organisation operating on a not-for-profit basis - meaning not only that you and other members actually own the organisation and share in all of its assets, but also that there is no “profit margin” built into your subscription. Whatever you pay is used to serve and support you and your fellow members, to keep them safe, and to protect their immediate and longer term interests.

We have been calling for a fixed-cost regime... and it’s fantastic that the government plans to cap excessive legal fees

MPS quoted in The Sunday Times 28 June 2015
**Value for money**

Most dentists live and work in the real world, where we develop a first-hand understanding of price, cost and value. We regularly tell our patients that you can’t expect to pay less and still expect to receive the same product and service, and we know that to be true in the purchasing decisions we make in our personal life. This expectation of “the same for less” makes no greater sense in the area of professional protection; when the chips are down, and when it matters most, you will want first class advice, support and representation, and expect nothing less than the best. At a slimmer down price you can expect no more than a slimmer down product.

Dental Protection offers a lot more than defence – it does not compromise on the size and strength of its advisory team, nor its dental and legal expertise. It provides more support, in more ways and on more occasions. We work tirelessly behind the scenes to apply pressure and effect change that will benefit all of our members, and we provide an unrivalled range of educational, risk management and other resources to protect you, even if you don’t happen to need our help on case-related matters.

But most importantly, the subscription you pay to us buys the peace of mind that comes from knowing you are with an organisation that offers more than just the basics. We are proud to be recognised as international leaders in the field of dental professional indemnity. And because we may just be one patient away from needing help and support, why take the chance?

I hope that you find plenty to interest you within the pages of this publication. Please take the time to read it, so that you are in a position to take advantage of your Dental Protection membership, and enjoy the full value that your subscription represents.

Kind regards,

Kevin Lewis
BDS LDSRCS FDSRCS(Eng) FF GDP(UK)
Dental Director
kevin.lewis@dentalprotection.org

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**Duty of candour**

The duty of candour, which was introduced by the government through Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, has been applicable to dental practices since 1 April 2015.

**The key principle behind “duty of candour”**

General practices must act in an open and transparent way in relation to care and treatment provided to patients. The statutory duty applies to organisations, not individuals, though it is clear from CQC guidance that it is expected that an organisation’s staff must co-operate with those principles to ensure the obligation is met.

Dental Protection continues to advise members to tell patients if something has gone wrong, for whatever reason, apologise if appropriate, and explain how it can be rectified. Where appropriate, reassurance should be given to any patient who is concerned about an adverse treatment outcome.

When complications and errors arise, you should be prepared to give your patients objective factual information about what has happened, in a caring and supportive fashion. You are encouraged to explain any clinical issues in terms that the patient is likely to understand.

Patients have a right to be informed of any matters which relate to their oral health, or to treatment provided for them; you should try not to withhold objective factual information or an expression of regret or sympathy where appropriate. Saying that you are sorry that an incident has occurred, or expressing your regret that a patient is upset or unhappy, is not necessarily an admission of guilt, fault or liability.

It may not be appropriate, however, to speculate or to cast blame unless and until all relevant facts are carefully established by proper and thorough inquiry. An inappropriate remark could prejudice your own interests and/or those of other practitioners.

If you are an employee, you will need to be aware of your employer’s duty of candour guidance and align your behaviour to this. If your practice has a robust system for incident reporting and reporting of significant events, it is likely to capture these notifiable safety incidents.

**Standards for the Dental Team**

The GDC makes clear the responsibility registrants have when working and communicating with patients.

**Principle two:** Communicate effectively with patients.

**Principle five:** Have a clear and effective complaints procedure.

**Principle six:** Work with colleagues in a way that is in patients’ best interests.

Search for “Candour” at [www.dentalprotection.org](http://www.dentalprotection.org) to learn more
More 2015 events for you

Full event information, including timings can be found on our website www.dentalprotection.org

UK Horizons
September 7–10

“Don’t Get Caught Out!”
Avoiding pitfalls in general dental practice

Following the success of the last seven years, Dental Protection is pleased to present another series of the popular evening roadshows in England in September. Dental Protection’s senior dento-legal advisers will present a lively and interactive session. This whole team event is designed to provide a wealth of information which can help you to practise more safely and manage your own risks more effectively

The presentations will cover:
- Where do the main problems come from?
- How can these problems be anticipated and managed?
- What are the key clinical records that need to be kept and why?
- What are the key consent issues and pitfalls?

Part 1: Claims in negligence

In this session we discuss how claims are resolved; illustrated from our extensive archive of cases.
- Why are some claims settled and why are some defended all the way to a trial?
- What can you do to reduce the chances of being caught out by an unwelcome claim?

Part 2: What’s happening at the GDC?

With almost 5000 complaints to the GDC and the Dental Complaints Service in the past year, practitioners are understandably anxious about what might happen to them if a patient complains to the GDC.

This session will explain the current procedure and explore the recent reform of the Fitness to Practise procedures and some other developments that are on the horizon. The talk will be illustrated with examples of past cases.

The impact of these changes on individual registrants will be explored and helpful tips offered about how to stay out of trouble...

To book tickets
Email
events@dentalprotection.org
Telephone
+44(0) 207 399 2914

Locations
Newcastle
Monday 7th September, Copthorne Hotel
Sheffield
Tuesday 8th September, Hilton Sheffield Hotel
Cardiff
Wednesday 9th September, Copthorne Hotel
London
Thursday 10th September, Cavendish Conference Centre

Early bird

Be an early bird and book your place before 31 July* to save £10 on your ticket (£30 for members and £50 for non-members). DPL Xtra practice members will be eligible for the early bird rate, which means the whole team can attend for just £30 each!

*Booking forms must be received by the Dental Protection team before 31 July 2015 to be eligible for the early bird rate

Dento-legal Study Day
October 16

The fourth annual Dento-legal Study Day will be staged at 30 Euston Square, which is a brand new venue for 2015. The study day is an unmissable event for anyone interested in dental law and ethics

Tickets are priced at £209 for members and £259 for non-members. A discount is available for DPL Xtra members, DCps and foundation dentists, who will pay only £179. Tickets for the event include 5.5 hours of core (law and ethics) verifiable CPD.

Premier Symposium
November 28

Dental Protection and schülke are pleased to present the fiftteenth annual Premier Symposium at the Shaw Theatre, Pullman St Pancras in London

The symposium offers five hours of verifiable CPD for all GDC registered members of the team, and will be an excellent opportunity for the whole team to mix with their peers and colleagues. The full programme will be available on our website shortly.

The conference is hugely popular so delegates are advised to book their tickets early to avoid missing out.
The cost of indemnity
Some important facts that we think you will find surprising

£facts

When viewed from a dento-legal and indemnity perspective, the professional environment in the UK is one of the most challenging that exists anywhere in the world. As the cost of professional protection increases, dentists naturally wonder if they can pay less and still receive the same level of protection and security.

Beyond compare
Many people would find it attractive to be offered an identical product at a lower price. Why wouldn’t they? But in professional protection, no two products are identical, so price comparisons are unwise and dangerous.

There is no such thing as “a really good cheap deal” in professional protection because you cannot charge lower rates and still cover the same risks with the same level of service and attention to detail. The sums just don’t add up.

The right price
Dental Protection has been the clear market leader for over 25 years, so we have by far the biggest amount of data, for more dentists, over all those years. It has more UK dental members than all the other providers put together. It also has all of its international knowledge and experience to draw upon.

As a result we are better placed than any other organisation in the UK dental indemnity field to know the true price that needs to be charged in order to provide responsibly for the present and long term future needs of our dental members.

With the best knowledge of the market, we charge the right and responsible price for the risks we take on and the high standard of service we are committed to providing.

The three main providers in the UK are all mutual (non-profit) organisations. So instead of asking why Dental Protection charges more than some of its competitors, it is more relevant to ask why other companies feel able to charge less unless they are planning to spend less. This in turn begs the question of where that cost cutting is going to happen.

We are committed to keeping our existing members safe and secure, not to place that security at risk with deeply discounted rates to chase extra market share. With 65,000 members on five continents, we don’t need to do that.
Putting the costs into perspective

- UK dentists are sued, on average, 2–3 times more often than UK medical GPs. Your chances of being sued are higher than ever before.

- We don’t “roll over” to the no win-no fee law firms. We regularly challenge the legal costs they charge and claim and have had many high-profile successes in holding these firms to account. Claimant law firms know that we will not simply “buy off” claims for an easy life. If we think that a claim can be defended, we will do whatever is necessary to defend it. In the long run this will discourage solicitors from bringing claims that have no merit or little prospect of succeeding. The more that indemnity providers “buy off” claims, the more claims there will be.

- We do not cut corners or look for the easiest and cheapest way out. We have a proven track record for fighting important points of principle on behalf of our members, to the highest courts in the land. We will often go further than other organisations, because our objective is the best possible result for each individual member, and sometimes for our members as a whole, not the lowest possible expenditure.

- The GDC reports that the number of complaints reaching them has doubled in the past four years and they expect to receive 3,500 “fitness to practise” referrals during 2015. They plan to triage 20 new cases every single day.

- Your chances of finding yourself with a GDC complaint to respond to, have never been greater. More and more of these cases are unrelated to clinical dentistry so even the best dentists, salaried dentists with NHS indemnity and DCPs of all kinds can still find themselves challenged by the GDC.

- In 2015, the GDC expects the average length of a hearing before the Professional Conduct Committee to be 4 - 4 ½ days. Hearings are held in parallel, with several running on the same day. The Investigating Committees plan to hear 11 cases every working day of 2015. Every one of these cases needs to be planned in detail for the member, with meetings and case conferences in the preceding weeks and months. This places a huge strain on the resources of any defence organisation, often paying for several defence teams supporting different members on the same day with a different team of barristers, solicitors, experts, dento-legal advisers and other support personnel for each hearing.

Some hearings can last 10 days or more and one recent case involves over 200 separate allegations, each of which needs to be responded to. The experience of going through a hearing, when your professional future is at stake, is very stressful. Dental Protection believes that you need the best and most experienced legal representation, selected to be right for the individual case. You have the best support when you need it most.

If we think that a claim can be defended, we will do whatever is necessary to defend it.
The cost of indemnity

The cost of a hearing
The GDC refers to a surprisingly high proportion of its incoming cases to the Interim Order Committee (IOC), where you can be suspended until the case is finally considered and evidence is heard. These IOC hearings are often heard at quite short notice and the GDC plans 150 IOC hearing days in 2015 alone. You could suddenly find yourself unable to practise, with no entitlement to any compensation if you are subsequently cleared of the allegations. So you need to be sure that your defence organisation has the resources to react swiftly and decisively with little or no prior notice, to avoid an adverse interim order being made against you.

A GDC hearing and associated costs typically costs in the region of £10,000 per day and it also can cost many thousands of pounds to prevent a case getting to a hearing. A single GDC hearing of average length could consume anything up to ten years’ worth of professional indemnity subscriptions. Wouldn’t you prefer to have the best and most experienced team on your side on those occasions when it matters most?

Other kinds of complaint
These have been increasing by 25-30% year on year for the last few years involving NHS Commissioning and Payment agencies, the Dental Complaints Service, the Ombudsman, Independent Safeguarding Authority, Advertising Standards Authority, the Information Commissioner’s Office (Data Protection), CQC and many other agencies.

Speed and getting the right response first time is crucial when responding to complaints. Your defence organisation needs to have the resources to respond swiftly and effectively in order to resolve complaints at the lowest level before they escalate and involve other bodies. As the UK’s leading provider of professional protection to dentists, we accumulate much more first-hand experience of all these agencies than other organisations.

Fighting costs
We could sit back and do nothing about any of the recent problems at the GDC, in the NHS and in the claims environment, declaring that it is all beyond our control – but we don’t. Instead we fight very hard on behalf of our members to hold back this totally disproportionate momentum that has been building up in recent years.

An example of this was our robust response to the GDC’s Consultation on its proposals to increase the Annual Retention Fee, which has been widely praised across the profession. All of our activity of this nature is published on our website so that our members can understand what we are saying and doing on their behalf.

We believe - and hope you would agree - that this is really important. Because the majority of UK dentists are members, we feel a responsibility to fight these battles when others might not be prepared to do so.

This makes sense because our own members stand to gain the most from our willingness to challenge these excesses and establish important points of principle. But these battles also cost money in the short term in order (we hope) to save your money in the longer term by helping us to contain future subscription increases. If we simply roll over and take the easy course, subscriptions will continue on a steep upward path and none of us wants that.

Amazing support
We have more UK dental members than any other UK defence organisation. This gives us much more experience of both claims trends and GDC fitness to practise cases. We regularly challenge GDC processes and decisions, and other agencies of all kinds when they are not acting fairly and reasonably.

We have a team of over 70 dento-legal advisers, over 30 of whom have legal as well as dental qualifications. Many are also registered specialists.

We have the depth of resources and expertise to meet multiple demands at the same time on the same day. A small team can’t possibly be in several places at once and somebody has to lose out. The size and strength of our team avoids that happening. We can make sure you can always get the support you need, when you need it and tailored to your specific needs.

We have a further team of almost 100 local advisers based throughout the UK and Ireland and trained to support the work of Dental Protection. This team can be mobilised to maintain service levels at times of exceptional demand. When you need support provided to you locally, we can deliver that too. On some occasions local knowledge and contacts can be crucial in getting the best outcome for our members. Many members tell us that they felt much more strongly supported in the knowledge that this extra help and support was at hand from experienced colleagues.

We have been a strong and trusted partner assisting and supporting dentists at every stage of their professional career for over 120 years. We have no intention of sacrificing the value of your membership by failing to charge the right price in order to be prudently funded.

£acts

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The case
In 1999, Nadine Montgomery gave birth by vaginal delivery to Sam. The birth was complicated by shoulder dystocia. Medical staff performed the appropriate manoeuvres to release Sam but, during the 12-minute delay, he was deprived of oxygen and subsequently diagnosed with cerebral palsy.

Mrs Montgomery is diabetic and small in stature and the risk of shoulder dystocia was agreed to be 9-10%. Despite expressing concern to her consultant about whether she would be able to deliver her baby vaginally, the doctor failed to warn Mrs Montgomery of the risk of serious injury from shoulder dystocia or the possibility of an elective caesarean section.

It was also alleged that delivery by caesarean section ought to have been offered to Mrs Montgomery, and that this would have prevented the child’s injury.

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.

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 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.
Stephen Henderson describes a campaign that has fundamentally changed the way in which the GDC’s Investigating Committee operates

Behind the scenes
Dental Protection has regularly engaged in formal and informal stakeholder liaison with the GDC on behalf of all the UK dental members.

Most readers will be aware of the robust response that Dental Protection submitted in response to the ARF debate (http://ow.ly/P1HXJ) which set out many concerns about the FTP process. Behind the scenes, Dental Protection and other key stakeholders including the BDA have been campaigning for a major change in the way that the Investigating Committee (IC) carried out its work.

Dental members may not always be aware of the amount of time that is spent behind the scenes, working with the GDC to effect change for the better. By providing you with a little more detail, you can see for yourself the benefits to the membership as a whole.

Who knew?
In the aftermath of all the less glorious events at the GDC over the past year, and the relentless adverse publicity they have attracted, the recent change in the operation of the GDC’s Investigating Committee has gone largely unnoticed and in fairness to the GDC, this stormy background has eclipsed much of the good work it has been doing in this regard. Although the result has had little recognition, it has, in fact, taken several years of persistent dialogue and private campaigning for the rights of all registrants to be protected, without compromising the interests or safety of the public in any way.

The GDC is exceptionally keen to engage with key stakeholders when they are reviewing operational processes, developing new guidelines and policy. These interactions can range from informal meetings, at the earliest stages to a full scale public consultation. You can find all our own consultation responses under the publications tab on the Dental Protection website.

If the Fitness to Practise procedure (FTP) is working fairly and proportionately, we could expect decisions to be reasonable, just and promptly delivered.

Getting the test right
Dental Protection has had a concern that, for years, the IC was not applying the correct legal test when considering a case, with the result that far too many registrants were being referred forward for further investigations and a hearing. This has been raised in private meetings with the GDC on numerous occasions over the years. And we have warmly welcomed the fact that the Faculty of General Dental Practice has supported our views on this by providing access to their guidance standards on line, publicly sharing our stated concern that the FGDP standards were often being quoted and applied out of the context for which they were intended. FGDP has helpfully clarified their proper interpretation.

The fact that the incorrect legal test has too often been applied is evidenced by the higher than expected number of cases that are closed after the investigation, without a hearing. Far too many cases were referred forwards for a hearing only for the GDC’s case not to be made out and the respondent’s fitness to practise found, not to be impaired. This begs the question of whether a hearing was ever really necessary in all of these cases.

In September 2014, the defence organisations met with the GDC’s (former) Director of Regulation and his team, telling them that the profession had lost confidence in the process that the GDC was operating; up to and including the IC. We explained why we did not believe that the legal test was being properly applied.

What’s going on?
Follow up
The next stakeholder event was to be an invitation to the new IC panellists training day in March 2015. In January 2015 the defence organisations met again to agree the nature of the presentation that we planned including (amongst other things) why we thought the panel was applying the wrong test.

It came as a pleasant surprise to find that the day before the training event, new IC guidance had been issued, which clearly set out the legal test to be applied by the panel. The delegates to the training event were, at last, on the same page by the time we arrived.

Clarification
The legal test is that the IC has to determine whether the facts alleged are likely to be proved, on the balance of probability. This requires a finding that something is (however narrowly) more likely to be true than not true

If the facts are likely to be proved the next question is whether or not these facts could or would amount to “misconduct”. This means a departure from an accepted standard of professional conduct/behaviour/practice which is on a serious (as opposed to a minor or moderate) scale.

The consequence of this clarification to the IC is that fewer cases will now be referred for a hearing. This will result in many fewer sleepless nights for members facing the threat of public sanction, suspension or erasure. It will, in the long term, result in a lower expenditure on defending cases that should never have been referred in the first place. This will inevitably have an impact on future subscription levels, once the current logjam of cases is behind us.

Stop!

Standards
In addition to our private representations and lobbying, the BDJ* published an article by the Dental Director Kevin Lewis, making the case that the profession was increasingly being judged – in courts of law, by the GDC and elsewhere – against inappropriate and excessively testing standards. Many published standards from a variety of sources are “aspirational” in nature and were never written with the intention that they should be interpreted as the bare minimum acceptable standard to be achieved. We argued that it is more likely that you will be found to have performed below an acceptable standard, if the “bar” of acceptability has been set in the wrong place to start with – as we believe it has.

The new Investigating Committee guidance came as a pleasant surprise

*Professional standards and their escalating impact upon the dental profession; Lewis, K; BDJ 2015; 218: 381-383
What is happening at the GDC?

Two recent cases

Both serve to highlight the importance of making sure that the GDC follows the correct procedures in dealing with cases before the Professional Conduct Committee (PCC).

Case 1

In the first case an independent specialist orthodontist was instructed by the GDC to advise on the care and treatment provided by a member facing the Professional Conduct Committee (PCC). In giving evidence, it became clear that the expert had not properly understood his role, which was to be an independent adviser to the PCC, commenting on the clinical aspects of the case. The expert indicated that he believed his role was to be an advocate for the interests of the patient, which was to completely misunderstand his role. That meant that his evidence to the PCC may have been biased and not neutral.

Dental Protection’s barrister made an immediate and successful application for the whole of the expert’s evidence to be disregarded by the PCC. The consequence of that order was that the prosecution case collapsed and the case against the member was dismissed.

When an expert is instructed by either the defence or the prosecution in any court the expert is required to sign a declaration confirming his/her independence, amongst other things. Anyone accepting instructions as an expert needs to make sure they fully understand their role in the proceedings before agreeing to become involved. Any departure from the expert’s declaration may lead to a claim in negligence against the expert personally, as well as contempt of court and professional misconduct proceedings.

Case 2

In a second case, again involving an expert going beyond their remit, and a number of serious errors on the part of the GDC in the way the case was prepared and conducted, Dental Protection’s barrister made a successful application to have the case stayed because the GDC abused the process, compromising the fairness of the hearing.

The GDC had agreed with all of the defence organisations that the prosecution papers and draft allegations will be provided four months before the hearing allowing the defence three months to prepare. In this case, papers were still being disclosed as late as the night before and morning of the hearing.

Late disclosure compromises the ability of the respondent member to be able to properly prepare a defence, compromising the fairness of the process. The GDC’s expert had been compromised because the papers showed that the expert – far from remaining independent - had in effect been directing the investigations throughout, even to the extent of suggesting allegations and lines of enquiry that would help the prosecution case. Once again this is an example of the impartiality of the expert being fundamentally compromised.

Looking to the future

Dental Protection and MPS are actively engaged with the key stakeholders in professional regulation (the Government, the GDC and GMC) in order to explore what professional regulation will look like in the future. The GDC has a Section 60 Order prepared and ready to be laid before Parliament, bringing in changes to the early stages of FTP cases, and the Law Commissioners have proposed wholesale reform of healthcare regulation. We believe that the new Government is keen to reform regulation and we will continue to lobby the stakeholders in the interests of our members.

Stop!
New standards for conscious sedation 2015

The report of the Intercollegiate Advisory Committee for Sedation (IACS) in Dentistry was published in April 2015 and replaces the previous document, Conscious Sedation in the Provision of Dental Care (Department of Health 2003)

There are significant changes in the new guidance, and although Dental Protection does not act an arbiter of clinical opinion, members offering sedation procedures to either adults or children will need to be aware of these developments and ensure they are compliant

Patient safety
Safety is the primary focus, and the report makes recommendations about information for patients, training for the entire dental team, sedation techniques and the appropriate environment for sedation delivery. As in other dental disciplines, for those colleagues who are already practising sedation to the standard of the previous guidelines, a grandfathering scheme has been included. The new guidance emphasises the need for team training rather than individual training and may result in more sedation centres rather than sedation practitioners working in many different practices.

Training programmes
The new standards apply to all those who practise conscious sedation procedures, whether they are dentists, doctors, nurses or dental care professionals and there are significant changes in what will be accepted as a training programme.

It is no longer acceptable for practitioners new to sedation to enrol on a course unless it has achieved accreditation by the IACSD and at the moment only courses provided by Universities or Deaneries are exempt form a course accreditation process.

As a result, there may be a shortage of courses on which to enrol and the acquisition of sufficient CPD may become a challenge. 12 hours of sedation-based CPD will be now be required, in a five-year cycle, for practitioners providing conscious sedation.

Other changes include the expectation that all members of a sedation team will be able to demonstrate training in the necessary life support skills which will include immediate life support in the treatment of adults and in the treatment of children. All dental nurses who currently act as the second appropriate person will be expected to study for the Certificate in Dental Sedation Nursing if they do not already hold that qualification.

Assessment
Anyone who is involved in any form of conscious sedation should carefully assess their current protocols and test them against the previous and the current guidelines. If they find they have not satisfied the previous guidelines they should regard themselves as practitioners new to sedation. If, after reflection, they completely satisfy the old regulations, the grandfathering situation may be applicable.

A summary of changes in the new guidelines

1 If you already practice sedation techniques and are confident that you satisfied previous guidelines
Refer to page 87 of the new document where transitional arrangements are clarified. This introduces the need to create a comprehensive log of the details of each case. In addition check the following aspects of your sedation training:

- Validated CPD
- Regular audit and reflection
- Competence in rescue skills
- Meet requirements for environment and equipment described in care pathway
- Ensure appropriate clinical governance is in place.

2 If you already practise sedation but are not sure you satisfied the previous regulations
Consider all your previous theoretical and clinical training and reflect on whether it would be sufficiently robust to present to GDC if required.

- If that is not the case you might wish to consider yourself new to sedation and engage with the new guidelines.
- Help to make such a decision can be sought from a local postgraduate deanery, or an organisation such as SAAD.

3 If you are new to sedation and wish to begin sedation practice

- Refer to the new sedation guidelines.
- You will need to complete and be assessed on an accredited course. As yet the accreditation scheme is not in place and it may take a while to be established. It would make sense to ask the course organisers if their course meets the requirements for accreditation and if it will be accredited.

The link to the new guidance is http://ow.ly/PSNNw.

As was mentioned, Dental Protection is not able to act as an arbiter on clinical matters such as this, although we can, as always, provide general guidance and “signposting”. Members are welcome to contact the dento-legal advisory team if further assistance is required.

Sedation
A technique in which the use of a drug or drugs produces a state of central nervous system depression enabling treatment to be carried out, but during which verbal contact with the patient is maintained throughout the period of sedation. The drugs and techniques used to provide conscious sedation for dental treatment should carry a margin of safety wide enough to render loss of consciousness unlikely.
Claims

An examination of the trend in large claims that members are currently experiencing with dental implants and periodontal disease

It is a curious fact that during the past five years, two types of cases have progressively started to monopolise the top of the leader board in terms of the largest cases we are seeing in the UK. Cases of this nature have nothing like the same prominence in any other country where we work, and this does invite the question of what is so different about the UK to explain this striking variation.

The cases in question involve either periodontal disease, or implant dentistry (or both) - and some common themes can be identified in many of these cases.

The average value of these claims is well in excess of the total subscriptions that a full rate general practitioner in England and Wales would pay to us over their entire practicing career. The costs and damages in the largest of these claims alone (an implant case) are more than £750,000, so it doesn’t take long to work out that these cases and others like them are making a significant impact on the overall picture where UK claims are concerned.

Implant cases

These cases are increasing both in number, frequency and cost. The size of the claims account for a disproportionate share of our total claims expenditure as they increasingly represent a higher proportion of all the cases currently under our management. It is not surprising, given this recent history, that implant dentistry is more of a concern than was the case five to seven years ago. These are concerns that are known to be shared by the General Dental Council (GDC).

Cases arising from implant dentistry can be related to either the placement of the implant fixtures, or the restorations or prosthetic appliances supported on them. In a significant number of cases, an element of both is involved, and where two (or more) clinicians are involved in the treatment of the same patient, any or all of them can become drawn into the claim. This is particularly likely when there is any question about the case assessment and treatment plan, or any lack of co-ordination or communication between the various clinicians.

In all the implant and periodontal cases shown opposite, those aspects of treatment are the primary issue giving rise to the claim, but some of the cases also include further allegations in relation to other aspects of treatment.

Two of the 20 cases involved four clinicians (including a hygienist) and two involve two clinicians. All the other claims involve a single clinician.
Another noticeable feature amongst the growing number of implant cases overall, is the appearance of more “late failure” cases, especially involving so-called “peri-implantitis”. These cases can be attributed to the clinician who placed the implants, or the clinician who provided any subsequent treatment, but more commonly both, at least while the case is being investigated and an expert opinion sought. Another feature is that these claims can additionally include clinicians (whether dentists or hygienists) who have examined or treated the patient subsequent to the provision of the implant(s) and restorations placed upon them and failed to identify and act upon the situation. There is a growing consensus amongst those involved in the field of implant dentistry that we will be seeing more of these cases in the years ahead.

Within the surgical component of implant dentistry, bone grafts, sinus lift procedures of various kinds, collateral damage to nerves and other adjacent structures, and problems resulting from incorrect positioning and angulation of fixtures, all contribute to their share of cases. A fairly recent and worrying development appears to be a tendency for some practitioners to become involved in implant dentistry surprisingly early in their career. Possibly this reflects a degree of over-confidence or a lack of awareness of their relative inexperience and competence in the relevant procedures involved. The extent and quality of one’s training in implant dentistry is likely to come under close scrutiny not only in the investigation of a clinical negligence claim, but also if the GDC becomes involved. Dentists whose training is centred on courses run by manufacturers and distributors of implant systems, and who claim special expertise in implant dentistry (eg on their websites) while having no formal specialist training or recognised qualifications, are exposing themselves to particular risks. That said, there are also some implant manufacturers and distributors who host perfectly legitimate courses run by expert clinicians (see page 18 for more on training).

Implant dentistry is almost always private dentistry, of course, and the costs involved can contribute to patients being less willing to tolerate and accept unfavourable outcomes

On occasions, expectations are raised during the planning and consent processes that may not be met, leading to avoidable disappointment. Experience and training in patient communication is therefore highly recommended.

Periodontal cases
These cases present problems for a variety of reasons.

- Unlike cases with a single, specific incident date, they cover extended periods often stretching back many years and sometimes involving more than one practitioner (and also, hygienists).

- Where patients are able to demonstrate that they had not been advised of the presence and significance of their periodontal disease, and have only learned this relatively recently (for example, when seeing a different practitioner), the normal three-year limitation period may be set aside or waived. This is what has made these cases so attractive to the “no win-no fee” law firms, because it has greatly expanded the potential number of claims that they could bring on behalf of their clients. In the group of high-value cases above, more than half of them involved or included treatment carried out in the 1980s and 1990s when subscription levels were very much lower. Those subscriptions had been set in blissful ignorance of the (“Wolff”) reforms to the Civil Justice System which paved the way for the arrival of the “no win-no fee” law firms a few years later. Our subscriptions back in the 1980s and 1990s now look modest when compared to a 2015 settlement cost of £125,000+ for a single case.

- The “dream ticket” for these law firms has been when they have been able to identify a dentist who has not been diagnosing and managing periodontal disease well, over many years. When they find one or two cases involving the same dentist, it is not unusual for them to place advertisements or “advertorial” in local newspapers, naming the dentist involved, highlighting the amounts of money that they have achieved for other patients whose gums were bleeding (for example) and inviting other such patients to contact them. In many instances the firm(s) of solicitors often made a lot more money out of these claims than they had secured for their clients.

- These periodontal cases tend to be large in terms of the future treatment costs that form part of the claim, but they are also arising in significant numbers and more troublingly, these numbers are increasing. Most of these claims cost between £25,000 and £75,000 to settle but many of them cost £100,000 or more.

- Even where practitioners are adamant that they had told the patient over many years about their periodontal disease, given advice regarding oral hygiene, smoking cessation and other risk factors and regularly monitored periodontal health and bone loss, we are often disadvantaged by clinical records which do not confirm these facts in sufficient detail (or at all). Few practitioners could be entirely confident that there are no such cases lurking in their filing cabinets from 10 or 20 years ago (or the filing cabinets of practices that they left). The advent of computerised records has not solved this problem and in some respects has made it worse.

We are likely to see more late failure (“peri-implantitis”) in the years ahead

Susan Willatt
Susan is Head of Dental Services
Claims

Impact of NHS changes

One of the concerns we had voiced at the time of the changes in the GDS and PDS contracts in England and Wales ten years ago, was the potential risk created by the UDA system where the management of periodontal disease was concerned. In many cases the new arrangements effectively removed any kind of remuneration for the treatment of periodontal disease, or at least introduced a powerful financial disincentive that had not existed previously. The disappearance at that time of the narrative and provisos that had accompanied the fee-per-item remuneration system also removed the specific requirement to have recorded BPE scores and full mouth probing depths in certain situations.

Those who had always (and quite rightly) viewed this as an important part of the monitoring of periodontal health, continued to do this, but those who had viewed it as a tedious administrative burden imposed by the NHS, no longer felt the need to keep these records and as a result have unwittingly left themselves especially vulnerable to these claims. This is a perfect example of the law of unintended consequences at work, coupled with an alarming disconnect between the aim of legislative changes and their practical impact - but the cost looks set to run into many millions of pounds and we can expect these claims to be arriving at our door for many years into the future.

Common themes

We have discussed the fact that these cases tend to arise and be reported to us much later than cases of other kinds of dentistry. These intervals can be of many years and this brings its own problems in terms of being able to remember details that are not immediately apparent from the records, or even, remembering the patient at all. Many practices find it difficult or impossible locate records dating from 20 or 30 years earlier.

Smoking cessation advice, where necessary, needs to have been provided and followed up (as discussed on page 23). Patients need to fully understand the possible (or likely) consequences of not acting upon this advice in their own particular case, to avoid the suggestion that they had not appreciated that continuing to smoke might affect their oral health and/or the prognosis of treatment provided.

Many patients have been known to argue that this crucial link had never been properly explained and they had simply thought that they were being given general advice. Inevitably the argument continues along the lines that they would have acted very differently had they only known the dental and oral consequences of continuing to smoke. Many patients seem to find themselves strengthened in this view after visiting a solicitor’s office.

When managing these cases, one is often left with a feeling that a practitioner either under-estimated the complexity of the case or failed to take appropriate and timely actions that might have mitigated the severity of the eventual outcome and consequences

A heightened awareness of how important (and frequent) these cases are becoming, and a pro-active commitment to appropriate management (including referral to specialist or more experienced colleagues where applicable), would help to hold back the approaching tide that these high-cost cases represent.
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 worrying recent claims statistics arising from implant dentistry.

Per-Ingvar Brånemark (1929–2014). The Swedish physician regarded as the “father of dental implantology”
The minefield of implant dentistry

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 (i.e. the ability to practise implant dentistry under both direct and indirect supervision, where help is readily at hand if you should need it).

The GDC is concerned, in particular, about dentists who become involved in implant dentistry with relatively little formal, structured training and mentoring. Their existing guidance (see panel above) is clear in stating that dentists should not get involved in treatment for which they do not have the relevant training and in respect of which they are not yet competent.

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 is almost certain to be referred to a Professional Conduct Committee 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 GDC) 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 (a criminal offence) and/or of advertising standards.

Standard 7.2
You must work within your knowledge, skills, professional competence and abilities

7.2.1 You must only carry out a task or a type of treatment if you are appropriately trained, competent, confident and indemnified. Training can take many different forms. You must be sure that you have undertaken training which is appropriate for you and equips you with the appropriate knowledge and skills to perform a task safely.

7.2.2 You should only deliver treatment and care if you are confident that you have had the necessary training and are competent to do so. If you are not confident to provide treatment, you must refer the patient to an appropriately trained colleague.

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 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.
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 GDP. 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 9)

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.
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 tranquility” 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 Ionising Radiation (Medical Examinations) Regulations (IRMER), 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:
- the additional imaging was (or was not) necessary in the circumstances of the specific case,
- 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

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 ongoing 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 and loss 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.

Well-rehearsed teamwork optimises clinical outcome for the patient
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 i.e. 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
https://www.nice.org.uk/guidance/ph10
http://www.ash.org.uk/stopping-smoking/for-health-professionals/smoking-cessation-services
https://www.dentalhealth.org/our-work/mouth-cancer-action-month
Domiciliary dental care in care homes
How to minimise risks when treating patients away from the dental surgery

As the population ages, more challenges are emerging in delivering oral healthcare for older adults. In England and Wales, the numbers of people 65 years and older, now numbers 9.2 million (16% of the population). Of these 337,000 live in a care setting and 31% live on their own.

Domiciliary dental care is undoubtedly an essential part of maintaining the health and wellbeing for those homebound patients who cannot, for a variety of reasons, attend a dental practice for treatment. Frail older people, in particular, have shown a preference for home visits for dental care. This allows them to use their limited energy on receiving the dental care, rather than on travelling to the dental practice. For some patients, the most disabled and those who are bedbound, it can be both difficult and distressing to be transported out of their home to a dental surgery.

The most common issues that the dental team will be asked to deal with for the elderly resident in a care home setting will be check-ups, oral cleaning, adjusting dentures or provision of new ones and simple restorative treatments to maintain the worn dentition. Providing oral hygiene advice to both the elderly resident and their carer, is both straightforward and rewarding, and could prevent many future problems. Training carers in oral healthcare provides a useful insight into what it is like working in a care home, and whether you wish your practice to develop a domiciliary dental care service there.

“Your Dad’s had a fall and broken his teeth...”
Domiciliary dentistry, or dentistry performed away from the dental surgery environment, is not something that either the profession or the public think about very often. But consider a not uncommon scenario – your elderly disabled father, living in a care home miles away, has a fall and breaks his hip and his denture in the process. You will feel eternally grateful to the domiciliary dentist who visited, offered professional and sympathetic care and allowed him to smile again.

Dentistry in care homes
This article focuses on providing dental care in care homes, both residential and those with nursing provision. For the practitioner new to providing dentistry outside of the surgery setting, this is a good place to start. Additional considerations not covered in this article would be required for providing dental care in a patient’s own residence.

Risk assessment checklist
It is vitally important to carry out a risk assessment checklist before doing domiciliary work. Ensuring the safety at all times of the dental team and your patients, is a leadership and management role of the dental practitioner. We can consider the risks of domiciliary dentistry under the following:

- Location of domiciliary visit
- Information gathering before your visit to ensure good communication with the care home, residents, relatives and your team
- Medical, mental health and social histories
- Employer’s liability
- Personal protection
- Equipment, including emergency equipment
- Moving and handling
- Infection protection and control
- Clinical waste
- Safeguarding issues
Heather Lloyd
Heather is a specialist in special care dentistry and former director of community and salaried dental services. She is a past Hon Membership Secretary and current President Elect of the British Society of Gerodontology

The application of fluoride varnish together with oral health education for patients and their carers is a low-cost preventive strategy for house-bound patients

<table>
<thead>
<tr>
<th>Risk</th>
<th>Risk reduction</th>
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<tbody>
<tr>
<td><strong>Location of domiciliary visit</strong></td>
<td>Check full address, postcode and telephone of the particular part of the care home you are visiting. Several houses or units may be located on one site within a large complex. Check if visitor parking is available at the care home, or whether there are any parking restrictions on the road.</td>
</tr>
<tr>
<td><strong>Information gathering before your visit to ensure good communication with the care home, residents, relatives and your team</strong></td>
<td>Make the initial telephone call to the care manager (subsequently you may be liaising with a Team Leader or Key Worker) and give the names of the dentist or hygienist and dental nurses visiting. Send the appointment details, together with your contact details, in writing to the care home manager and resident. Where appropriate, communicate directly with the resident’s relative, and invite them to be present for the visit. If you have been asked to specify a time for your visit, give a time period of one hour to allow for unexpected delays and/or traffic. A delay may cause annoyance or anxiety. Inform the care home manager/staff that the dental team will be wearing identification badges. A mobile phone should always be carried to communicate with your practice, the care home and for your personal safety. Prior to your visit, establish whether the resident has any pets. These may be a safety risk to the dental team in terms of contaminating your equipment, or being bitten! It is appropriate to ask for pets to be put elsewhere when you visit. Check whether the care home has a clinical room.</td>
</tr>
<tr>
<td><strong>Medical, mental health and social histories</strong></td>
<td>Ensure your team knows details of the resident/s you are visiting. Share appropriate information in a confidential manner both at the team briefing before you go on the visit, and written clearly in the patient’s notes. Ensure you and your team are up-to-date with your Consent and Mental Capacity Act training.</td>
</tr>
<tr>
<td><strong>Employer’s liability</strong></td>
<td>Check that both you and your staff are insured to practise outside the environment of a dental surgery. Check that the car driver is insured to use their car for the business of domiciliary dentistry.</td>
</tr>
<tr>
<td><strong>Personal protection</strong></td>
<td>Personal safety is paramount. It is a legal requirement that a third party is present when the dentist or hygienist visits a care home resident. The dentist or hygienist would routinely be accompanied by a dental nurse, but occasionally the operator may visit a care home unaccompanied (e.g. a dentist may make an urgent visit to relieve pain caused by a denture rubbing). In these circumstances, the operator MUST be accompanied by a member of staff from the care home when visiting the resident. Mobile phones and, if necessary, personal alarms, should be carried by the dental team. The dental team should decide whether to wear uniform or smart non-uniform clothing on care home visits. In some locations, it would be wise not to be recognisable as a health team. Always give your practice an approximate time of return from the visit, and notify them if you will be returning later than expected.</td>
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</table>
Domiciliary dental care in care homes

Risk

<table>
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<th>Risk reduction</th>
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<td><strong>Equipment including emergency equipment</strong></td>
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| **Moving and handling** | Dental teams must know how to move and handle both equipment, and patients, to avoid incurring injuries either to patients, themselves or colleagues. A trolley is a good idea. Within the care home setting, dental teams should request the assistance of a carer or carers, if residents need to be transferred from their chair or bed for dental care. |

| **Infection protection and control** | Infection protection and control must be to the same standards that are applied in the dental surgery. Visors rather than facemasks are very useful for patients that need to lip-read, or who are anxious. Disposable plastic aprons should be worn over uniforms or clothing. Whether you are working in a dedicated clinical area of the care home, or the resident’s own room, the area must be zoned into clean and dirty areas. Resident’s clothing must be protected from spillage. If a spillage occurs, inform a member of the care home staff and follow the Health and Safety guidelines of the care home. Disposable, single-use items should be used wherever possible. Dirty instruments must be kept separate from the domiciliary kits and transported in rigid securely lidded containers. Any sharps used must be transported in a sealed sharps container. All laboratory work should be rinsed on site but disinfected back at the dental surgery. This should be labelled to avoid confusion with contaminated clinical waste for disposal. |

| **Clinical waste** | Environmental Protection and Hazardous Waste Regulations, along with any local guidelines should be adhered to, for the storage, transport and disposal of clinical waste. In a care home setting, yellow bags and sharps containers will be available to use. Any waste that is transported back to the dental surgery should be double-bagged and transported in a rigid container. |

| **Record keeping** | There is a need to maintain detailed records of any interaction with (or in relation to) every patient. Protecting the security and integrity of patient information both in transit and in the home can be a challenge. It is crucial that all relevant information about a patient and their dental care is available, complete and up to date at all times and can be accessed when needed. |

Generation-friendly family practices

For the whole dental team, providing regular care to a care home located near their practice is both a personally rewarding experience and a practice builder. With the application of correct professional standards, including meticulous record keeping, providing dental care outside the environment of the dental surgery can offer a refreshing change of scene for the busy dental practice team.

There is no better advertisement for the local general dental practice than to be known as the generation-friendly family practice that sees all members of the family wherever they are located.

References

BSDH Guidelines for the Delivery of a Domiciliary Oral Healthcare Service August 2009
Oral healthcare for Older People 2020 Vision check-up January 2012
British Dental Association
2011 census data Office for National Statistics
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 one of the update courses on medicine and oral medicine which take place across the UK. 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?

NICE Guidelines and Infective Endocarditis

You will be very aware of the recommendations by NICE (CG64, 2008) for the cessation of routine antibiotic use in patients undergoing invasive dental treatment in the prevention of infective endocarditis. However, work by Dayer et al (2015) has caused NICE to revisit their guidance.

The paper by Dayer et al reports that, "Prescriptions of antibiotic prophylaxis for the prevention of infective endocarditis fell substantially after introduction of the NICE guidance (mean 10,900 prescriptions per month [Jan 1, 2004, to March 31, 2008] vs 2236 prescriptions per month [April 1, 2008, to March 31, 2013], p<0.0001). Starting in March, 2008, the number of cases of infective endocarditis increased significantly above the projected historical trend, by 0.11 cases per 10 million people per month (95% CI 0.05-0.16, p<0.0001). By March, 2013, 35 more cases per month were reported than would have been expected had the previous trend continued. This increase in the incidence of infective endocarditis was significant for both individuals at high risk of infective endocarditis and those at lower risk."

They go on to say, "Although our data do not establish a causal association, prescriptions of antibiotic prophylaxis have fallen substantially and the incidence of infective endocarditis has increased significantly in England since introduction of the 2008 NICE guidelines."

It was known in 2008, before the introduction of the Guidance that the incidence of infective endocarditis was already on the increase worldwide. NICE, at the time of writing, have an addendum open for consultation and comment. You may wish to review this and any subsequent information offered by NICE at http://ow.ly/P5W8l

What is clear, for dentists looking after patients at risk of developing infective endocarditis, is that optimising oral health is a priority

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).
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.

**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) and so 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 form the patient’s GP.

**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 apneic episodes, oral dryness may, again, be experienced. Such patients should also be offered augmented preventive advice.

**References**


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

- Paternalistic
  - Dentist opinion
  - Patient

- Informative
  - Dentist information
  - Patient

- Shared
  - Dentist information and opinion
  - Patient information and opinion

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.  

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


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. The literature also suggests that when patients make these decisions they are more satisfied.

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.

**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) says “You must recognise and promote patients’ rights to and responsibilities for making decisions about their health priorities and care.”

**Figure 1**

**Decision points and options**

Patient condition → Decision point → Option A  
Option B “No action” → Option C

The NHS Constitution (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.

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.

---

2. Coulter A, Collins A. Making shared decision making a reality: No decision about me, without me. London: King’s Fund, 2011.
5. GDC. Standards for the Dental Team, 2013
6. NHS. The NHS Constitution, 2013
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 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

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.

Benefits of shared decision making

- 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.

Contacts

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

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