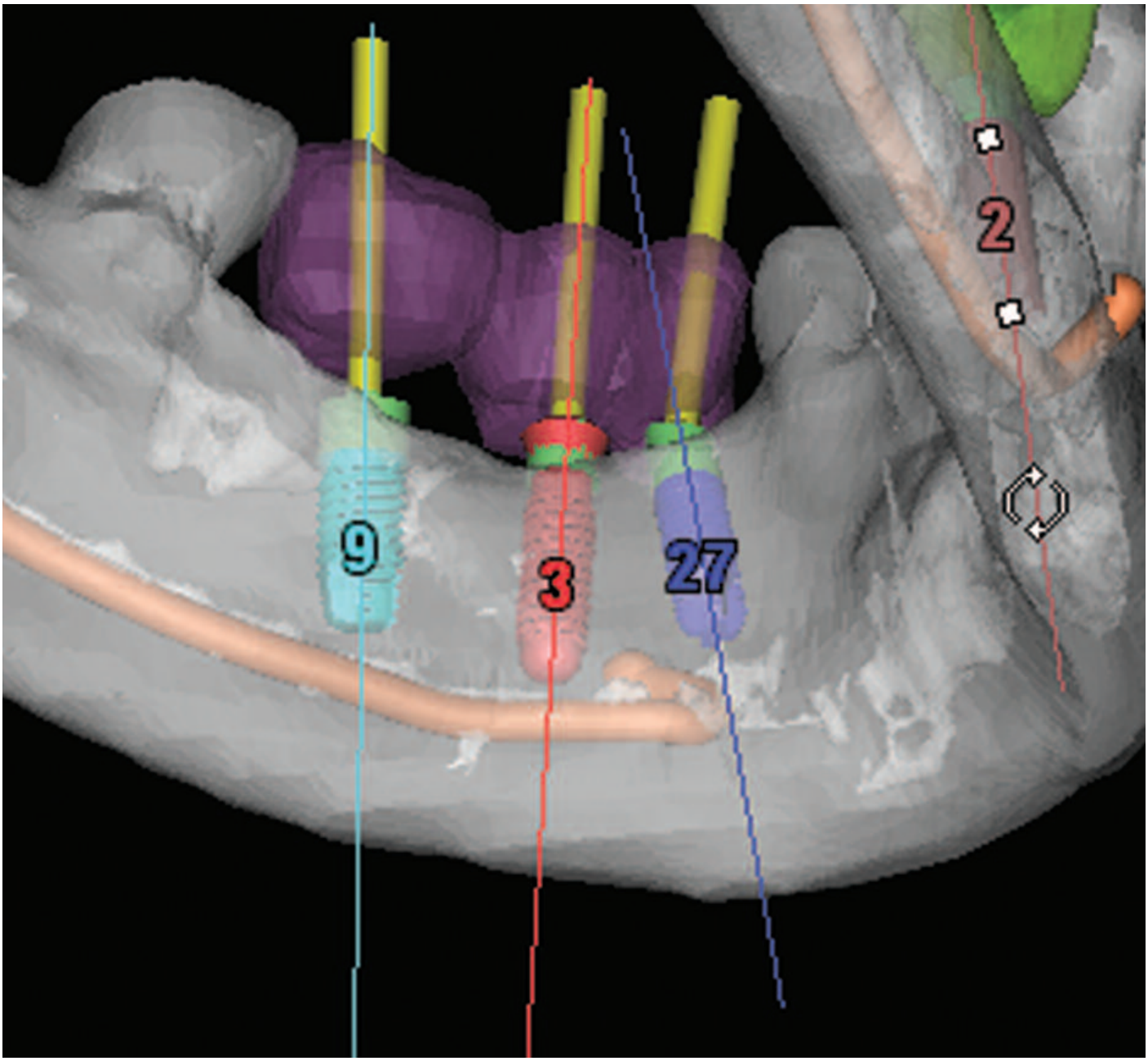
South Africa

Dental Protection

Riskwise

Risk management from Dental Protection



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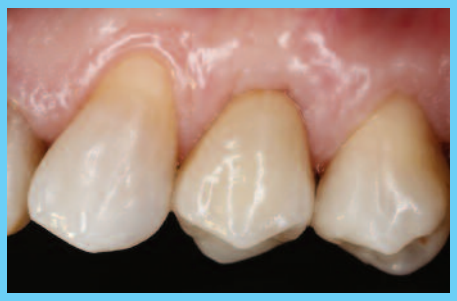


Editorial

Alasdair McKelvie
Head of Dental Services, Southern Africa

Maretha Smit

Welcome to the latest edition of *Riskwise South Africa*.

Our Ethics For All Conference will be happening in October and you will find details on page 6. This will be an excellent opportunity to meet many old friends and new members of our organisation. We are holding the event in three different venues and I hope you will find one of them convenient to attend.

On the road

Dental Protection likes to hear from members and learn exactly what additional support we can offer your dental team. This has been the rationale behind the annual roadshow held earlier in the year. Although the overall attendance at some events was not as high as it has been, I am unsure why there were less members at these events, given that our overall membership continues to thrive.

It might be that midweek evening events are inconvenient. It may be that the lecture topics are not what you need. With your input, we can shape the 2017 roadshow to your specific needs. The chance to meet you personally, to hear where you need support and to understand any occasions where service has not met your expectation is incredibly important to us.

Before next year's roadshow, I would like to invite you to email me personally and share your thoughts - particularly around how we might improve the roadshow.

In this issue

There should be plenty to interest you in this issue but I would like to pick three articles that particularly caught my eye.

The focus on implants in this issue highlights risks that can be avoided and also describes the importance of all the dental team monitoring the health of the implant, even if they were not involved in its placement.

If an employee commits a negligent act or omission whilst acting in the course of their employment, the employer can be held vicariously liable for any resulting claim. On page 7 one of our panel of South African attorneys, Nicola Caine, has some tips to prevent this happening.

On page 17 there is a reminder of the powerful effect you can have on a patient by apologising if something goes wrong. It's a quick read but a valuable lesson for all member of the dental team.

The Dental Director

Dental Protection has a new Dental Director, Dr Raj Rattan MBE. Many of you will have heard Raj speak at various congresses in South Africa and, along with all the other dentolegal advisers, I very much welcome his appointment and we all look forward to working with him in the future. Meanwhile I hope you will enjoy this edition of *Riskwise*.

Best wishes,

Alasdair McKelvie BDS LLM
Dental Protection, Head of Dental Services, Southern Africa
alasdair.mckelvie@dentalprotection.org

Bon voyage

Maretha Smit, CEO of SADA, is moving on to New Zealand. The relationship between Dental Protection and SADA has many points of mutual interest. Despite some challenges along the way, those benefits continue thanks to the friendly support of the SADA team over many years. Dental Protection wishes Maretha and her family good health and happiness with her new project.

> "With your input we can better shape our service to your needs"

Update

Changes to the team for South Africa


Dr Raj Rattan


Dr Kevin Lewis


Dr John Tiernan


Allison Newell

The new Dental Director

Dr Raj Rattan MBE was appointed Dental Director for Dental Protection this summer

Dr Rattan has over 30 years' experience in dental practice and has been associated with Dental Protection for over 20 years, first as a dentolegal adviser and more recently as a senior dentolegal consultant. He uses his extensive knowledge and experience to inform debate through his published articles, books and international lectures on risk management, quality assurance and practice management.

> It is a huge privilege to be given the opportunity to lead a very talented team who are dedicated to dentistry. Members in South Africa should be reassured that if they face a difficult situation that arises out of their practice, they will receive assistance from experienced dentists with legal training, who will help them at every stage

"I want to build on the past success of the organisation and focus on providing a world class service for our members, so that together we are better prepared to meet future challenges."

Dr Kevin Lewis steps down

Kevin had served as Dental Protection's Dental Director since 1998

> It has been a real privilege not only to work in this fascinating field over so many years, but also to work with such phenomenally good people. There is something very special about being in a position to help your professional colleagues through times of difficulty, and one of the pleasures of the job is seeing that commitment and passion running right through the Dental Protection team

"There has also been a lot of travel involved so it has been quite demanding and it will be nice to have a bit more time to call my own after next summer. I will certainly be looking forward to that, and also to continuing my writing and lecturing for some time yet."

Dr John Tiernan retires

John first joined the organisation in 1993 and was very active on behalf of member in South Africa

His career spanned over numerous other roles including Assistant Dental Director, Director of Educational Services and most recently Executive Director of Member Engagement, where he was pivotal in creating the shape of our educational benefits for members.

> The dentolegal environment has changed dramatically. What was a traditionally slow-moving environment is now an ever-changing world of regulatory and legal challenges. The number of complaints and the volume, cost and complexity of claims has significantly increased over the years. I wish Dental Protection and most importantly the membership, well for the future

New International Executive Director

Allison Newell becomes our very first executive director of international operations

The Dental Protection/SADA roadshow in May coincided with Allison's first visit to South Africa. She came to our events in Bloemfontein and Johannesburg, and had the chance to meet dental members and to understand the pressures and difficulties of working as a dentist at a time when operational costs continue to rise almost at the same rate as complaints to the Health Professions Council. She will help us to effectively deliver a world-class service of protection, in partnership with members' needs.

A personal take on record keeping

Dr Alasdair McKelvie

I cannot remember one edition of Riskwise, or even a lecture I have given, that did not make reference to record keeping and the value of having sufficient information recorded about all your patients and their treatment, should you subsequently be confronted with a challenge. The ability to protect yourself in the face of a legal or regulatory challenge is one of the many benefits of keeping effective records

Continuity of care

It is very easy to convince yourself that all you have time for is to list the treatment carried out, but both the clinician and the patient need to be fully aware of what treatment has been completed and what has yet to be done Frequently, I see records that contain a series of ICD-10 codes and very little else. This is of course helpful when a non-clinical member of the team has responsibility for submitting the claims to a medical scheme, but it does not help you, the patient or anyone else looking at the record to understand why this treatment was carried out or what other treatment options were discussed, considered and declined.

Recording clinical symptoms and the outcomes of simple vitality or percussion tests is important in all situations, but even more so in those cases where it is extremely difficult to establish with certainty why the patient is in pain.

Personal experience

My own worst experience in clinical practice involved a treatment in which I went from tooth to tooth extirpating pulps, thinking I had at last solved the problem; only for the patient to return with the same symptoms of pain. I lost my way, and when challenged I could not justify all the treatment I had carried out because the records did not contain sufficient information, particularly around the investigation of the symptoms and my analysis of the outcomes leading to a diagnosis.

What was illogical about my actions was not the systematic extirpation of a number of healthy pulps, but the failure to record the factors that led to my clinical decision. I had been able to justify the decision to myself at the time, but without the existence of any record, no one else would regard the outcome as the work of a caring and conscientious practitioner, but more as an act of carelessness and negligence from someone who didn't really care for their patient. I learned the hard way, but I never made the mistake again.

Assessment

The challenges we face as clinicians mean our records can be used as a measure of our competence and professionalism just as much as the quality of our clinical work. Professionals in all walks of life keep records of meetings, phone calls, financial transactions, service histories and even feedback. Can you imagine placing your trust in a bank that did not keep an accurate record of all your transactions, or flying with an airline that did not enforce the use of a pilot's log?

We all are capable of making mistakes and poor decisions, and when judgement time comes, the individual who keeps a good record, as professionals should, will more often than not gain the benefit of any doubt; particularly when there are two versions of the same incident (the patient's and yours).

The last word

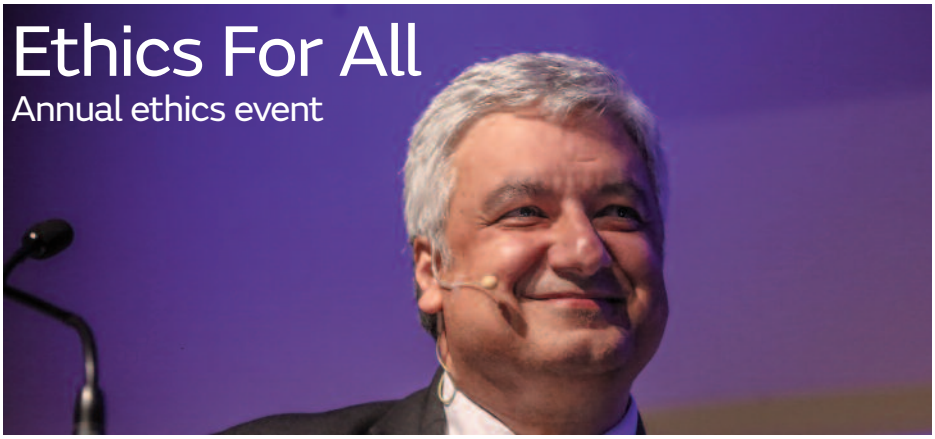
Dental Protection had to settle two claims this year where the records were so poor that we were unable to establish what the clinician's starting position was. In both cases, extensive crown work had been provided and subsequently failed very quickly. Our advisers thought that most of the teeth were probably already doomed before the crowns were provided - but with no records and no x-rays to prove it, we were unable to challenge the size of the claim.

The message is clear. Failing to complete a good record is not only ethically unacceptable, it fails to protect both you, the clinician, and your patients who expect records to chart their clinical journey. Sadly a poor record also undermines the interests of all your colleagues who do keep good records, as they all have to contribute to the increasing cost of indemnity.

> "Records are a measure of competence and professionalism

Ethics For All

Annual ethics event



Given the significance of clinical negligence claims and complaints, it is important that dentists receive straightforward and effective advice about how to avoid adverse outcomes

Dental Protection and MPS are hosting a conference – Ethics For All – for dentists, and other healthcare professionals in October in Pretoria, Durban and Cape Town.

The event provides an opportunity for members to examine ethical challenges and enables attendees to obtain CME points for the ethical component of their professional development.

It brings together highly respected local and international speakers from the healthcare profession and beyond to provide guidance to help you practise safely and ethically.

Dr Alasdair McKelvie, Senior Dentolegal Adviser and Lead for Africa says:

We know that issues surrounding ethics and professionalism can be challenging for dentists to navigate and, although we're here for dentists when things go wrong, we very much want to help them get it right in the first place. It's about preventing pain for dentists and their patients.

We have an exciting programme featuring presentations delivered by leading keynote speakers, covering topics including:

- Dentolegal and Medicolegal Update – Complaints, Claims and Risk
- Balancing the Ethics of Business Practice and Healthcare
- Redefining Defensive Medicine – Can the Use of Clinical Protocols Help?
- Mediation
- The Ethics of Looking After Yourself

The event is free of charge for Dental Projection members and a full copy of the conference programme can be found online at dentalprotection.org/ethicsforall

Don't miss this opportunity to debate key dentolegal and ethical issues with your peers and hear from leading experts on ethics.

Pretoria
Saturday 1 October 2016

Time
0830 registration, 0930 start, 1300 close, followed by lunch

Location
CSIR International Convention Centre, 1 Meiring Naude Road, Pretoria, 0001

Durban
Sunday 2 October 2016

Time
0830 registration, 0930 start, 1300 close, followed by lunch

Location
Durban ICC, 45 Bram Fisher Road, Durban, 4001

Cape Town
Thursday 6 October 2016

Time
1730 registration, 1830 start, 2130 close, refreshments available on arrival

Location
Cape Town International Convention Centre (CTICC), Convention Square, 1 Lower Long Street, Cape Town, 8001

Cost
Free to Dental Protection members
For more information and to register to attend visit
dentalprotection.org/ethicsforall

Protect yourself

Nicola Caine explains how to protect yourself from the risk of vicarious liability that could result in you being sued for another dentist's negligence

Nicola Caine LLM
Nicola has practised as a litigation attorney since 1992. Amongst other things, she represents dental practitioners facing claims and assisting with responses to complaints to the She is a director at MacRobert Attorneys and heads up its Cape Town office

Dr X is an experienced dentist who has been a member of Dental Protection for 20 years. He employed a young dentist, Dr Y, who performed an endodontic procedure on Mr A whilst working at Dr X's practice. During the procedure, the endodontic file broke off in the canal and Dr Y was unable to remove it; the tooth eventually had to be extracted

Approximately six months after treating Mr A, Dr Y resigned and moved to Canada. One year later, Mr A sued Dr X for the damages that he had suffered as a result of Dr Y's treatment, based on Dr X's liability for the conduct of Dr Y, his former employee. Upon receipt of the summons, Dr X contacted Dental Protection and requested assistance with the defence of the claim.

Whilst considering Dr X's request for assistance, Dental Protection ascertained that it was Dr Y and not Dr X who had treated Mr A. It ascertained further that Dr Y had not been a Dental Protection member at the time that he had treated Mr A. Dental Protection was therefore unable to provide Dr X with assistance, as the claim related to Dr Y's (not Dr X's) treatment of a patient. This was because Dr X was only entitled to assistance in respect of treatment that he, himself, administered. More particularly, his benefits of membership did not include protection for the treatment administered by other dentists. Consequently, Dr X had to instruct attorneys, at his own cost, to defend the case.

Assumptions are dangerous

Many dentists incorrectly assume, just like Dr X, that their indemnity arrangements will extend to any claim instituted by a patient, including claims against dentists employed by them. Although it is correct, in law, that a patient may hold liable not only the dentist who treated him/her (Dr Y) but also the employer of such dentist (Dr X), or both, it does not follow that a defence organisation will provide protection for claims based on the employer being vicariously liable for the conduct of his/her employees.

The membership subscription for each Dental Protection member is calculated on the risk represented by a single member. It does not include protection for claims that result from the conduct of a (potentially unlimited) number of dentists employed by such a member. To provide this level of protection would be unfair towards other members who pay the same subscription but who do not employ any dentists, or whose employed dentists all have arrangements for their own protection.

Avoiding a claim

How, do you protect yourself against claims resulting from treatment administered by other dentists who work at your practice?

- Primarily, by ensuring that any dentists working at your practice are not employed by you. Instead, they should be independent contractors. It is, however, important that such a dentist is, in fact, an independent contractor (ie. not only in name). The mere fact that an employed dentist is described as 'a locum' will not preclude you from being held vicariously liable for the locum's conduct. Whether or not a dentist/locum is working as an independent contractor depends largely on the nature of the working relationship.

Protect yourself

- A truly independent contractor will, for example:
  – be registered as provisional tax payer;
  – work his/her own hours; (It bears mentioning that according to the ethical rules of the Health Professions Council of South Africa, locums may be appointed for a maximum of only six months)
  – run his/her own business;
  – be free to carry out work for more than one employer at the same time;
  – invoice the practice at which he/she is performing the locum each month for his/her services and be paid accordingly; and
  – will not have PAYE or UIF deducted from his/her invoice and will not receive a car allowance, annual leave, sick leave etc.

- Even if you are able to ensure that locum dentists working at your practice are, legally speaking, independent contractors and not employees, there is no guarantee that patients will appreciate this distinction and that they will not, adopt a "belt and braces" approach and sue both you and your locum.

- The best way to protect yourself against this is to ensure that dentists employed by you (whether or not they are legally speaking, independent contractors) are properly indemnified, preferably also by Dental Protection, and that this is confirmed in the written contract which you have with him/her. If both you and the dentist(s) whom you employ were to be members of Dental Protection at the time of treatment, both parties would be entitled to the benefits of membership and this would make the resolution of any future problems easier to manage since both parties would have the same rights to request assistance from Dental Protection.

  However, if different defence organisations or insurers were to be involved, the situation would be potentially prejudicial because Dental Protection would, as explained above, be unlikely to assist you if you were not personally involved in the treatment of the particular patient. Although the indemnity provider of the dentist(s) whom you employ might possibly agree also to defend the claim on your behalf, this is by no means a foregone conclusion. In any event, such indemnity arrangements might well not have your best interests at heart.

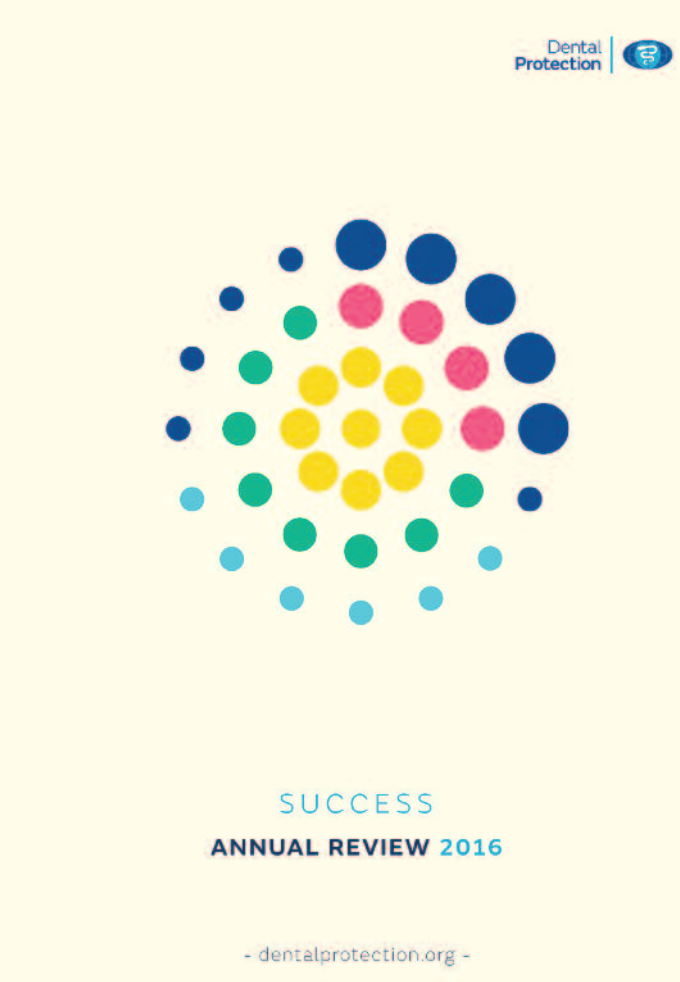
"Be pro-active; protect yourself against claims from the treatment provided by others

Getting the best out of your membership

You can find more information about vicarious liability in the latest edition of the Annual Review starting on Page 50

Your own personal copy of the publication was mailed to you earlier this year.

It is also available to download from the website if you look under the Publications tab at dentalprotection.org/south-africa



The minefield of implant dentistry

How to steer clear of avoidable problems

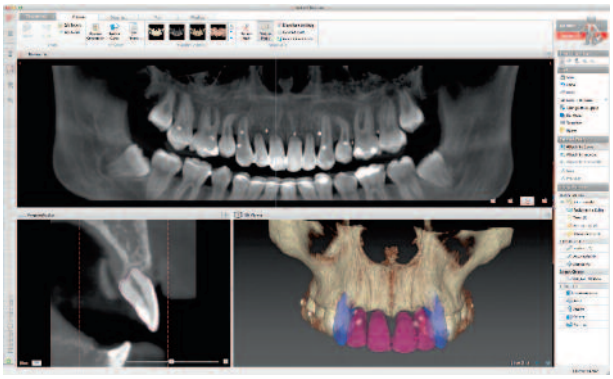
Per-Ingvar Brånemark (1929–2014). The Swedish physician regarded as the "father of dental implantology")

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

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

We are grateful to Nobel Biocare for the use of the images on pages 9–13

The minefield of implant dentistry



Collecting information about the case

Before you start

Get proper training

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

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

It is not difficult to see how exposed a young dentist would be if they get involved in implant dentistry quite soon after qualifying, perhaps off the back of a relatively short course undertaken with no proper curriculum or structure, supervision arrangements, quality assurance or opportunity for hands-on mentoring after completing the course. Were such a dentist, with relatively little (narrow) experience of clinical dentistry to undertake a complex restorative case which then goes wrong, this would be a matter of concern for the HPCSA should a complaint be made by that patient. 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 challenged particularly in relation to the way in which s/he had described their experience and training, skill and expertise in implant dentistry (eg. on a practice website). This can be the result of a genuine lack of insight into the level of their own knowledge and competence, or a wish for commercial or other reasons to appear more skilled or experienced than they really are. Either way these exaggerated and misleading claims are not likely to do the clinician any favours and may additionally be a breach of consumer protection regulations and/or of advertising standards.

The tools for the job

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

Check you have the right protection

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

Special categories apply to implant dentistry and associated procedures such as sinus lifts - 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.

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

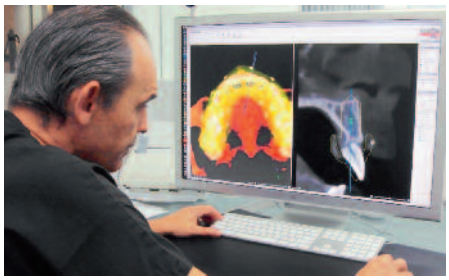
Getting started

Slow and easy

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

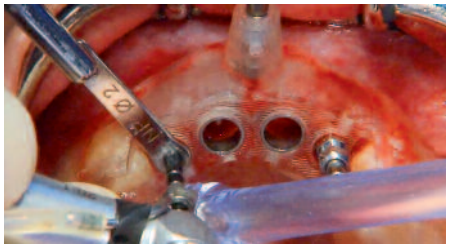
Mentoring

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



Planning

Communication with the patient



The right equipment and environment

Sharing care – when more than one clinician is involved

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

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

Implant fixtures are, of course, a means to an end and not an end in themselves. Consequently, implant dentistry needs to be driven, and led, by the prosthodontist – 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).

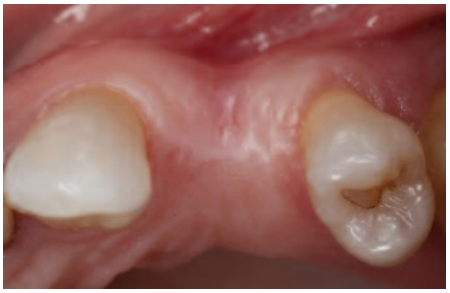
Nowhere is the need for this "seamless" approach more obvious than in the consent process; a patient needs to understand all material facts that relate to the surgical placement of the fixtures, and also to whatever appliance or restoration the fixtures will be supporting. A material fact is one that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

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

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

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

The minefield of implant dentistry



Case assessment and treatment planning

Plan carefully

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

In particular

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

Minimise risk and uncertainty

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

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

While there is always a cost attached to new technology, 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 imaging carried out. Equally, if the patient is unwilling to undergo this further imaging on cost or other grounds, the clinician has the right to decline to provide the treatment.

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

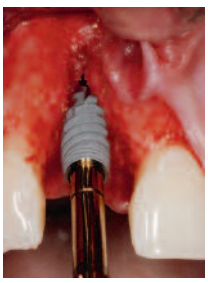
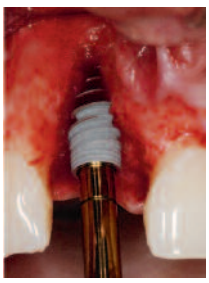
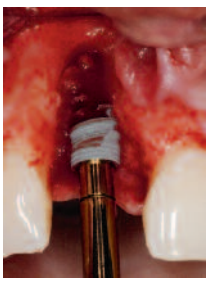
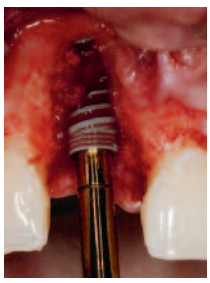
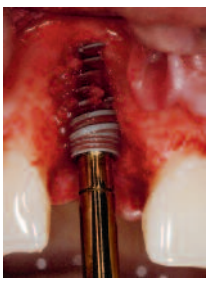
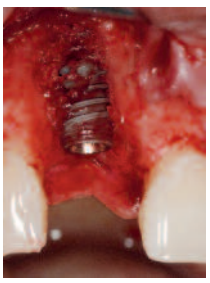
a the additional imaging was (or was not) necessary in the circumstances of the specific case,

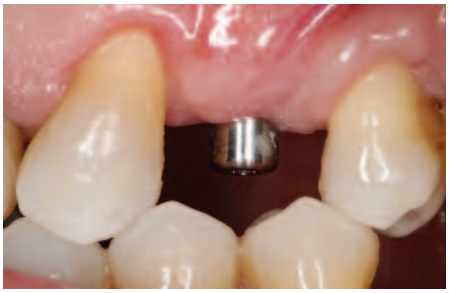
b a responsible clinician acting in the patient's best interests would proceed with placing the implants without the additional imaging being available.

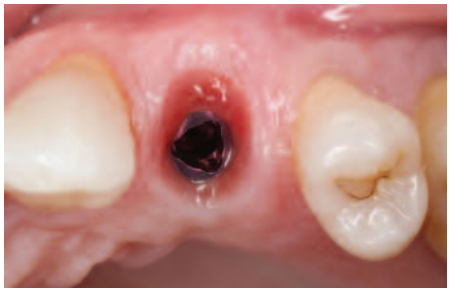
Another example of a step which improves predictability and reduces uncertainty (especially in an edentulous arch) is the use of stents and other forms of surgical guides where appropriate, and in more complex cases, the construction and use of surgical models.

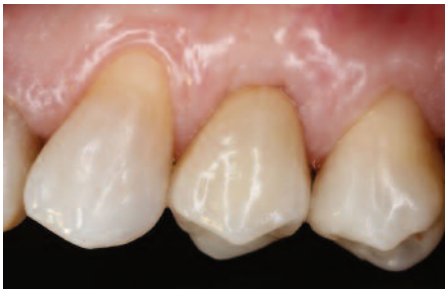
Spend time validating consent

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





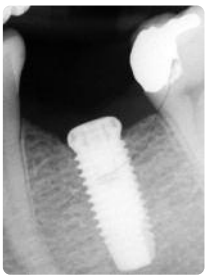


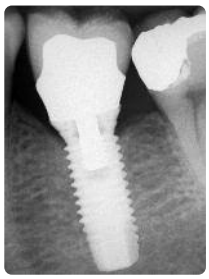
Some questions to ask yourself to help ensure the patient's consent is valid

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

The surgical phase - placing the implant fixtures

1. **Give appropriate pre-operative advice**
2. **Follow accepted procedures**
   Stay within the limits of your training and competence.
3. **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.
4. **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.
5. **Review the patient**
   Choose appropriate intervals following the procedure and especially in the days immediately following the placement of the implant(s)

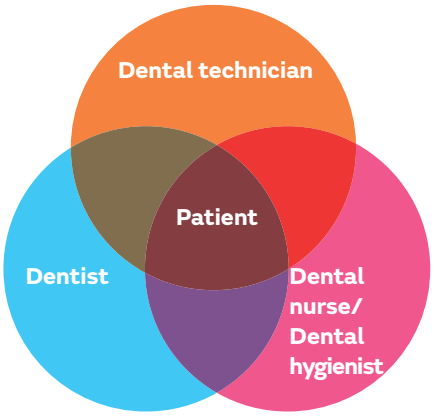




Regular monitoring of the bone height and soft tissues adjacent to the restored portion of the implant will alert you to the first signs of peri-implantitis

The minefield of implant dentistry

Well-rehearsed teamwork optimises clinical outcome for the patient



The prosthodontic stage

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

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

Follow up and monitoring

Maintenance

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

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

Keep your eye on the ball

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

Peri-implantitis is an inflammatory condition which can often be reversed at an early stage. There will be redness, swelling, inflammation and the tissues around the fixture will not look healthy. At this point there is no bone loss and it is a precursor to peri-implant mucositis. 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 involve 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

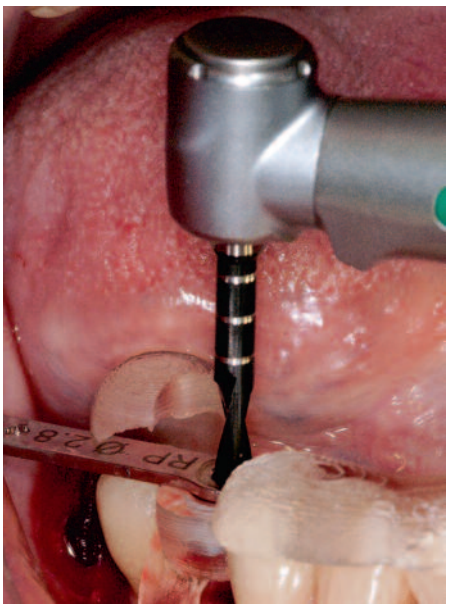
In implant dentistry, every stage of the process needs to be very carefully recorded. Especially important here are records of what the patient was led to expect, what information was provided to the patient, what warnings they were given etc.

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.



Timing is everything

Case study

Leaving a patient in pain whilst they wait for an appointment can carry risks

A dentist had treated an adult patient for almost a year. Recently the patient had attended with pain when biting on the right side of her mouth. No caries or fractured restorations were evident and the radiographs didn't allow the clinician to make a definitive diagnosis.

A provisional diagnosis of localised periodontitis was made and the dentist proceeded to treat the patient on this basis, with root surface debridement under local anaesthetic.

This treatment was undertaken two weeks after the initial appointment. Two weeks after the second visit, the patient returned having had no resolution of the symptoms and reporting that she had been in pain for a month. Indeed, the pain was increasing in severity to the point where it was described as excruciating, and she was unhappy.

After a further review it was discovered that a premolar had suffered a vertical fracture and needed to be removed. The dentist decided the extraction was potentially difficult and advised the patient that he could not carry out the extraction the same day and that a longer appointment would be needed.

Unfortunately, the dentist's appointment list was full and the next available "long appointment" was two weeks away. The receptionist explained this to the patient who reluctantly agreed to wait a further two weeks for an appointment of the right length. The patient had now been in discomfort for several weeks but, as she trusted the dentist, she accepted the wait was unavoidable.

The situation deteriorated and a few days later the patient called the practice in severe pain. She was seen by a colleague of the original dentist who removed the fractured tooth the same day, without any difficulty.

The patient was relieved that her tooth had been successfully removed and that her toothache had resolved. However, she was unhappy about the delay in receiving treatment, particularly as her dentist had advised that the extraction would be difficult and would need a long appointment, and this had proved unnecessary. The patient wrote to the dentist complaining that she had been left in pain for more than a month and that he was uncaring.
With Dental Protection's assistance, the dentist apologised to the patient and thanked her for making him aware of her concern. Having investigated the situation he established that there had been a lack of communication between the receptionist and himself which, in turn, left him unaware of the patient's long wait for a further appointment.

He also explained the potential difficulty with the extraction and his reasons for seeking a longer appointment slot. He explained that he fully understood the patient's concerns and that he would take steps to ensure that such a situation would not arise again. The patient accepted the apology and explanation and this concluded the complaint.

She was particularly happy that her complaint had been taken seriously and that changes would be made at the practice, which meant that another patient would not have the same unsatisfactory experience.

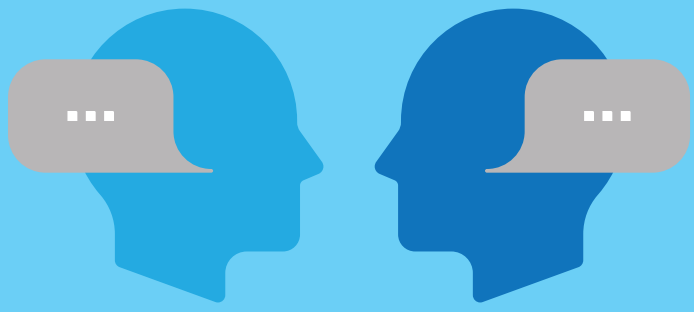
Taking control of arrangements

The dentist in this case had been unaware that the patient would have to wait so long for an appropriate appointment slot, and when her letter of complaint drew this to his attention he was disappointed by the level of service that his practice had provided to the patient.

It was clear that the receptionist had not realised that the patient was in pain and the dentist had not realised that his next available appointment was a matter of weeks away. There had certainly been a communication gap and a conversation together with his dental nurse and receptionist produced the necessary changes in the way that patients were prioritised.

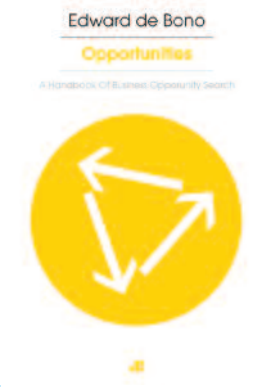
Learning point

Patients in pain who are treated as soon as possible are inevitably very grateful and can become amazing ambassadors for your practice. Patients who appear to be left in pain are never grateful and often feel the need to tell their story to other people.
A patient who has their complaint resolved can often go on to become one of the dentist's greatest supporters. A patient is often looking for an explanation and, where appropriate, an apology. The "wow" factor can be created by feeding back to the patient any changes which have been made as a result of the complaint.



The voice of experience

This article examines the contribution that experience makes in the effective management of clinical and dento-legal risks



Dr. Edward de Bono graduated in Medicine and had already pioneered the concept of "Lateral Thinking" when in his late 20s and early 30s, and over five decades since then has been an internationally acclaimed thinker, innovator, business guru and prolific author. His love for and many connections with Australia include having owned an island off the coast of Western Australia and having a street in Geraldton, WA named after him

When things go wrong, one of the first questions asked by Dental Boards and Councils (and courts of law) is that of *"how much previous experience did you have when you attempted the procedure?"* Over the course of a professional career we all build up that most valuable of commodities, experience. At the start of our career most of us are well aware that we haven't (yet) acquired very much of it, and we hope that our recent training and up-to-date knowledge will compensate for that fact

Each of us builds up experience in different ways. There is a world of difference between the experience gained simply by carrying out the same procedure again and again over an extended period of time (on the one hand) and the much deeper and more meaningful experience that can be gained through taking a much more structured and reflective approach, making a conscious and deliberate effort to learn from each occasion when you carry out the procedure.

Using the latter approach, one can build up an equivalent and arguably more useful reservoir of experience much more quickly, even if you have actually carried out fewer procedures in that time. The perspective of experience being a "reservoir" that you deliberately collect and store so that it becomes a resource to draw from when the need arises, is a helpful analogy. Experience is viewed by some as a kind of linear progressive "qualification", which it is only partially valid. Experience accumulated on the basis of "time served", without training and learning, and especially if it exists in the absence of deeper understanding, awareness and practical application, may actually end up being a disadvantage and a risk in itself, if it misleads us into over-estimating our competence.

Trapped by competence

Edward De Bono (see above) once[1] described the risk of being "trapped by competence", an example of which arises when your level of competence is sufficient for the daily demands of your occupation, and as a result you stop looking for ways to improve.

Another example of being "trapped by competence" arises when you are highly skilled in carrying out procedure A and your self-confidence makes you believe that the less familiar procedure B can't possibly present too much of a challenge for anyone with such proven expertise in procedure A. This often unspoken "How difficult can it be?" thought is very often the prelude to an embarrassing conclusion. Even eminent specialists have been known to fall into this trap when they encounter a new technique mid-career.

Sixth sense

There is another aspect of experience, however, which can be beneficial whatever your level of underlying competence. It can be significantly enhanced through deliberate training to achieve deeper knowledge and understanding (as occurs during specialist training, for example) but most practitioners in the later stages of their career will recognise their greater ability to sift the information before them much more quickly that they were able to do at the start of their career – and better still, to make sense of it.

When that experience is coupled with deeper understanding, however, not only do you know what to look for and what is (and is not) significant, but you are able to see things that the novice does not see because you have trained yourself to pick up patterns, nuances and subtleties that the novice will almost certainly miss. It is a skill just as essential for clinicians as it is for police officers and detectives, firemen, fishermen, barristers and judges, border control workers and many others.

Summary

1 Don't confuse experience (alone) with the possession of deeper knowledge and understanding.
2 Squeeze the maximum value out of whatever experience you have, at every stage of your career. Learn from your mistakes as well as your successes.
3 Recognise that experience alone is no substitute for genuinely deep knowledge and understanding. Every time you contemplate a new technique or procedure you become a student again.
4 Coaching and Mentoring are effective in speeding up the acquisition of learning, deeper understanding and increasing competence through experience.

> "Experience is like a reservoir - a resource that you can draw from when the need arises

[1] De Bono, Edward (1978). Opportunities. Penguin Books

The value of saying sorry

Dr David Croser
David is a general dental practitioner with many years experience and is the Communications Manger for Dental Protection

An apology - a sincere expression of regret and sorrow - is one of the most powerful instruments in a practitioner's communication toolbox. As dentists, we strive for perfection and it can be difficult to know how to act when a mistake occurs. I believe that most of us would want to apologise to a patient if there was a problem – even if it may seem like a trivial issue. But what about more serious issues, such as when a patient has been harmed? Might an apology encourage the patient to make matters worse if you apologise?

Dentists are well trained on clinical matters and increasingly so in effective communication but we must be prepared for managing errors and knowing what to do when an adverse incident occurs.

Candidly speaking

Dentists already have a professional and ethical duty to be open, honest, and to apologise when things go wrong. Dental Protection has long advocated for a culture change in healthcare; to change the reactions to incidents from fear, to an eagerness to explain, learn and report. For such an approach to succeed we need to work in an environment where staff are trained and supported in admitting errors and learning from mistakes, and where senior clinicians lead by example.

Concerns about the consequences of speaking up mean that members of the dental team sometimes hesitate to act when things go wrong. The desire to seem infallible coupled with a fear of recrimination can stifle an open approach to errors. As a result, a natural apology and explanation to patients can be lost.

A conversation with a patient after an error is one of the most difficult a practitioner can even if the risks and warnings of a particular procedure are outlined pre-treatment. Admitting something went wrong and saying sorry should be conducted in a sensitive, personalised and patient-centred manner. It is a response that can be difficult to practice because fortunately clinical errors in dentistry do not occur very often. But that is not quite the same thing as saying that things never go wrong.

The right thing to do

Effective management of an adverse incident has many benefits. Most importantly, the patient will understand what happened and receive a much sought after apology and recognition of the distress they feel. Learning can then ensue, in a blame-free manner, minimising the risk of the same error happening again.

Conversely to traditional teaching, when something goes wrong an open and honest explanation of what happened, including an apology, is likely to reduce the risk of a complaint. Much like the consideration of treatment options, dentist should be able to openly communicate and work in partnership with their patient to decide how to proceed.

Putting it into practice

The first step is to listen to your patient and understand why they are upset - they want to have their story heard and their distress acknowledged. Pay particular attention to non-verbal signs of feelings and emotions and attend to their comfort. This will go a long way in beginning to repair the emotional damage that has been caused.

Next, it is important to demonstrate an expression of regret or sorrow. You could use an apology of sympathy (for example, "I'm sorry this happened to you") or an apology of responsibility (such as "I'm sorry I/we did this to you"). In some cases, an apology is all that unhappy patients seek from their practitioner. An open and truthful discussion should follow, including a factual explanation of what happened and any anticipated consequences so the patient is prepared for what to expect going forward. If required, propose a plan for on-going management if the situation.

If you can't provide this, explain how the patient can obtain further help and assist with these arrangements by providing contacts and resources. This might mean referral to a specialist. For example if an instrument breaks inside a root canal, an extraction proves more difficult than expected or a root ends up in the maxillary sinus. It is important for the whole dental team to support each other if a problem is encountered, if they are to improve the patient experience in future and take full advantage of the learning that can come from errors.

Summary

The absence of a timely apology can have a significant impact. The literature supports the fact that when something goes wrong an apology is really important to the patient.

This subject is explored further in Dental Protection's 'Risk Management' workshops.

Two three-hour workshops are available, Mastering Your Risk and Mastering Adverse Outcomes. Both are free for dental members to attend as a benefit of membership.

For further information on Mastering Your Risk and Mastering Adverse Outcomes look under the events tab at dentalprotection.org/south-africa

Education - six themes that make a difference

Dr John Tiernan shares his personal view on education and training

One of the first questions that colleagues from Dental Protection are likely to ask a delegate when they are delivering education is "why are you here?" and the response is frequently, "I want to avoid being sued or avoid complaints"

It is hardly surprising that one of the most challenging events in a dental career is to be the subject of a patient complaint or a claim. For most dentists, this distressing event might arise once or twice in a career. Unfortunately, for some the frequency is significantly more. The key to reducing or avoiding patient complaints or claims is, in my view, education and training. Otherwise we are unlikely to acquire the necessary skills to manage this risk.

When deciding what to include in your professional development plan to help you reduce risk, the variety of education programmes can be daunting. Should you choose those areas where you have acknowledged weaknesses or those areas that interest you most? When it comes to risk, a broader approach is required because it will bring into focus a more comprehensive understanding of the various areas where such challenges arise.

What really creates risk?

Clinical competence is a key pre-requisite to successful dentistry; however, the real drivers of risk, as far as litigation is concerned, are frequently referred to as predisposing factors. These will often arise from the interpersonal relationship between the healthcare provider and the patient. The relationship between negligence outcomes and litigation are poorly documented. There is, however, evidence to suggest that those practitioners with poorer interpersonal and risk management skills get more complaints or claims.

In a way, this is good news because these are skills that can be learned by most people. That is the approach taken by us when designing our current educational programmes.

> Practitioners with poorer interpersonal skills get more complaints

What are the most effective strategies?

There are six key areas for professional development that support our initial training.

1) Predisposing factors

From a preventive point of view it is important to develop the knowledge of what really drives a patient to complain or litigate. These can include poor communication, lack of empathy, poor listening, unmet expectations and issues around manner and attitude among others. This is the focus of the Mastering Your Risk workshops. The objective is to give colleagues the skillset to reduce risk before events occur.

2) Adverse outcome management

Realistically most of healthcare is in the disappointment business. We provide care and treatments that patients would probably prefer not to have. Even patient-led care areas such as cosmetic dentistry can lead to profound disappointment when their expectations are neither understood nor met.

3) Challenging interactions

The world would be a great place if everyone agreed all of the time. Nevertheless, on a day-to-day basis, we have to manage differences of opinion and approach. Challenging interactions can result in complaints and claims if they are not managed. We are not the only industry that has to do this, however the stakes are high in healthcare.

4) Shared decision making

Shared decision making is yet to feature heavily in the dental literature. Two major meta-analysis reviews undertaken by the Kings Fund (1) and The Health Foundation (2) suggest that patients want to be involved in decision making. When patients are involved, they make better decisions for themselves and are happy with the outcomes. In some cases, not all, it leads to better outcomes. Whilst most of the studies are in medical situations, there is no reason to believe that dental and medical patients are different or behave differently. It is a skill to be able to balance your own therapeutic knowledge and desire to help a patient and ensure that the patient feels that they have had full autonomy over their decision. The patient should feel that their balance and preferences have helped them arrive at their decision.

Dr John Tiernan
John Tiernan qualified from Trinity College, Dublin, and worked in dental practice before joining Dental Protection. After 23 years serving members he retired from the organisation this summer

5) Risk management

Good systems and processes are an essential part of risk management. Such knowledge can be acquired through educational programmes even if many working within the profession do not have day-to-day control of their systems and processes. A thorough knowledge of how to tell good from bad allows a healthcare professional the opportunity to consider the risk of the environment they are working in. Armed with this information, strategies can be put into place.

6) Self-management

Dentistry is a tough profession physically and psychologically. You are working with patients who have varying levels of anxiety at different times. It is important to understand that the human is not a machine and the right work-life balance needs to be struck in order to ensure that you are best placed to provide care for your patients. A common feature of those with high risk of claims and complaints is that their work-life balance has been poor and burn out ensues.

In summary, six key areas of education and training can make a very significant difference to your risk profile. Education after qualification is part of professional development. Most of the subjects above are optional but my suggestion is that if you are going to take a holistic approach to risk, they are all an important part of that professional development cycle.

Dental Protection offers risk management workshops, free to members that cover these key areas of professional development. Book your place online.

References
[1] Systematic review of involving patients in the planning and development of health care: Crawford, MJ et al. BMJ 2002;325:1263
[2] Effectiveness of strategies for informing, educating, and involving patients: Coulter, A and Ellins, J BMJ. 2007 Jul 7; 335(7609): 24–27

“Attend one of our “Managing your Risk” half-day workshops to improve your communication skills

Adult orthodontics

Dr Alison Williams describes some of the problems that can arise from treating adult patients who are short of time

Dr Alison Williams
Alison is a specialist orthodontist who also works as a part-time Associate Dentolegal Adviser for Dental Protection

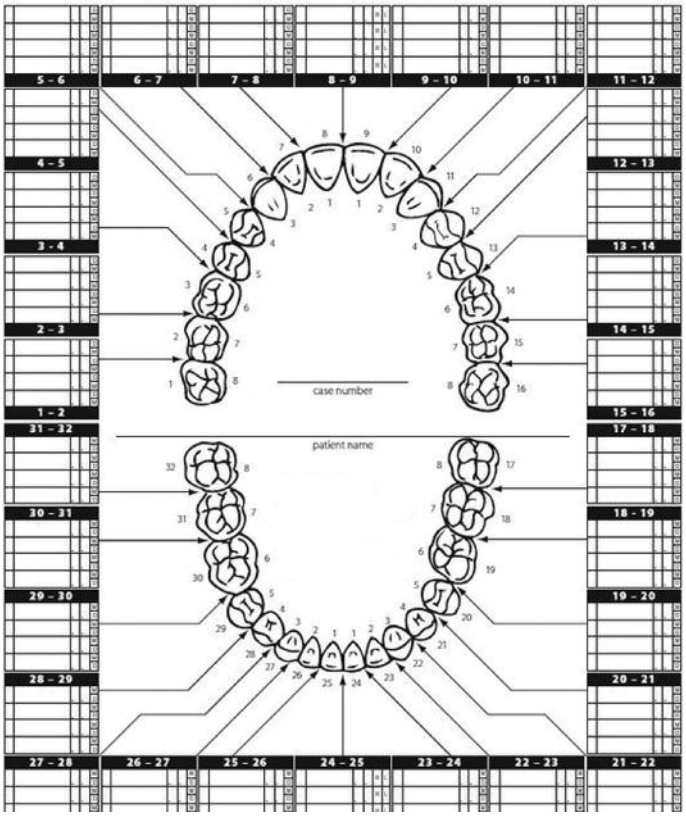
Since the 1960s there has been a steady increase in the number of adult patients seeking orthodontic treatment. The reasons for adults seeking orthodontic consultation may be to fulfil a past promise to self when the parents were unable to afford orthodontic treatment as an adolescent, to correct a minor relapse of past orthodontic treatment, or to provide corrective treatment prior to other dental treatment

Whilst adults and adolescents may have exactly the same reasons for seeking orthodontic treatment, the adolescent may not be emotionally involved in the treatment but adults have a better understanding of the treatment processes and usually with realistic expectations. However, underlying insecurities about treatment, appearance and other factors may lead to a complex set of unrecognised and abnormal expectations. Careful consideration has to be given to the reasons for seeking such treatment especially, when the reasons may be improved appearance with the perception that there may be rewards that are unrealistic or unattainable (new job, promotion, etc).

Adults also expect that treatment will be unnoticeable to family and work colleagues in order that they may continue confidently in their usual daily activities without embarrassment. This is achievable by the use of ceramic brackets, the placement of a lingually attached appliance or series of clear aligners, which will assist the creation of a positive perception in the wearer's mind. Some adults will wear an appliance as a badge of honour: others will live in total embarrassment.

As there is a limited possibility of skeletal change or growth in adult patients, without surgical intervention, it is often necessary to present treatment on the basis that extractions may be required to create space to unravel crowded teeth, or for enameloplasty in the form of interproximal stripping. In other instances, opening spaces to prepare for the replacement of a previously extracted tooth with an implant or a bridge, periodontal issues, pathologic occlusions and temporomandibular joint dysfunction matters may be part of the advantages of orthodontic treatment. Those requiring extra special care and experience to manage, but can provide rewards for practitioner and patient alike if treatment can be provided in a smooth professional manner.

Adults who commit themselves to an orthodontic treatment plan will have done so after a lot of thought and they are usually very compliant and cooperative with treatment, but be aware they may scrutinise every tiny tooth movement that occurs between appointments. This "expert" patient becomes more aware of his/her occlusion and the operator must be prepared to manage more questions and an additional number of "tweaks" to the treatment plan in order to satisfy his/her patient's expectations. It is important that all problems that may arise will be anticipated during the examination assessment and treatment planning of the patient. An inexperienced clinician may not be able to identify these hidden problems and try to transfer the blame for the lack of progress back onto the patient. This creates tension and frustration for both operator and patient, with the patient questioning the competence of the operator/clinician at every turn.



The laboratory need for interproximal enamel reduction in connection with aligner systems may be communicated to the clinician on a chart such as this. Sharing it with the patient will help to eliminate any surprises when you start the process

> The rewards of treatment can evaporate if patient expectations are not met

Unmet expectations

Adults seeking orthodontic treatment, especially in middle age, are presenting for a costly, uncomfortable, time-consuming and potentially embarrassing course of treatment, fully realising that they have made significant sacrifices to meet, perhaps unrealistic, expectations that the resultant straighter teeth may provide. It is important to realise that teeth move slower in adults and sometimes previously forecasted results can be impossible to achieve. The inexperienced clinician who has no understanding of biomechanics and what can or cannot be achieved, or perhaps skimp on the consent process, may encounter rather fiery discussions with their patients.

Clear aligner techniques

The use of clear positioning devices for minor localised tooth movements is not new but developments in data technology, 3-D printing, and other technology have facilitated novel techniques for the movement of teeth. These techniques were initially presented to experienced clinicians and specialists as an adjunct to their existing armamentarium. Commercial pressures have made the techniques available to all levels of experience within the dental profession, and have proved particularly attractive to non-specialists who have no recognised formal training or experience in orthodontics. One serious disadvantage is that the treatment plan and the series of aligners are formulated for the practitioner, usually at a licensed laboratory, meaning that the practitioner has very little input into the design and desired outcome for the patient's needs. The advantage is that the treatment is kept in-house rather than having to provide a referral to a specialist who is not part of the practice.

Just like the protection for these orthodontic models, good communication at the start of treatment will protect the clinician from unwanted damage

Recent studies by Dental Protection would indicate that claims arising from orthodontics are increasing significantly and 20% of those reported in 2010 involve clear aligners techniques. Significantly, general dental practitioners feature in 80 to 90% of the complaints and claims. This may be considered a worrying development, given the increasing popularity of this technique for patients and general dentists who provide orthodontic treatment.

A closer analysis of the cases reported revealed that the underlying causes were little different to other orthodontic cases and include:

- Failures in case assessment diagnosis and treatment planning and initial discussions with the patient.
- Poor diagnostic records.
- Deficiencies in the consent process especially in the relation to discussing alternative treatment approaches.
- Lack of foundation knowledge, inexperience and a failure to anticipate and recognise problems.
- Failure to recognise the absence of space to move teeth, and what is involved with interproximal reduction (IPS) and the provision of risk and warnings for that procedure.
- Failure to manage the patient's expectations - perhaps overselling the benefits of clear aligners without stressing the limitations of the product.
- Failure to include the possibility of the need for some fixed appliance therapy to obtain the best possible final outcome in terms of root position and stability. If this is introduced to the patient after it is recognised that goals have not been met, or progress is slow, it will form the basis for a potential complaint, as it is likely the patient was promised a "no braces" treatment plan.
- Failure to include and predict the need for long term retention, including fixed retention.
- Failure of a clinician with little foundation knowledge in orthodontic treatment and biomechanics to challenge the decision to alter a treatment plan made by the remote laboratory.
- Patient compliance – the success of clear aligner treatment relies on consistent wear of the appliance for the prescribed time. Patients who fail to meet this target may wish to progress to the next aligner in the series without the inexperience d clinician recognising that predicted tooth movement has not been achieved. The experienced clinician will recognise it immediately and amend the treatment plan accordingly.

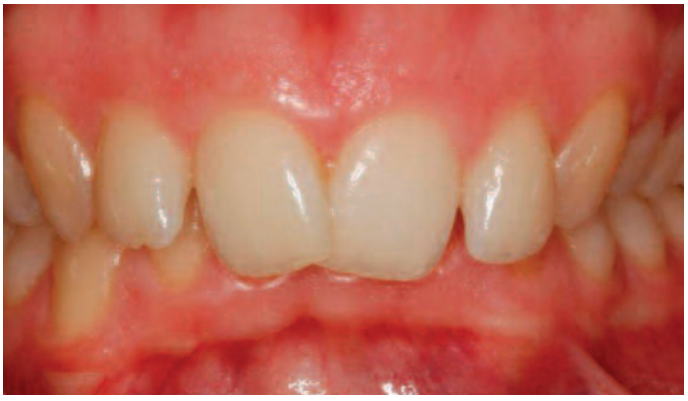
Adult orthodontics

Establish arrangements for the continuation of treatment if a staffing change is imminent and warn the patient

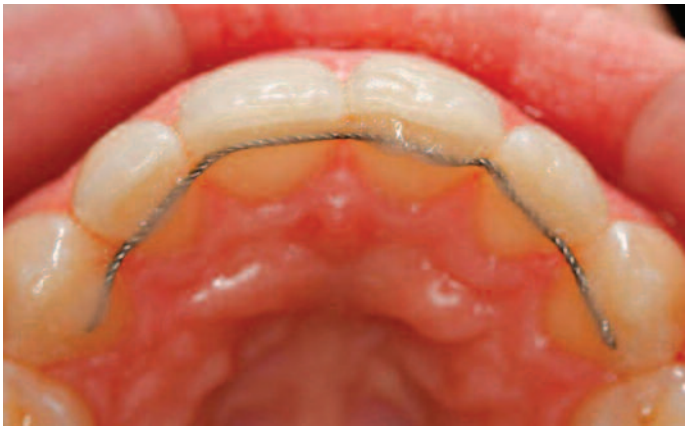
Quick and short-term orthodontic techniques

Branded short-term systems often include the promise of a quick fix to improve the alignment of teeth, sometimes prior to other restorative needs. Again the techniques promoted achieve limited improvements in the time allowed. The treatment will straighten anterior teeth, but has little effect on any underlying malocclusion which may contribute to long-term instability.

The short-term systems are attractive to clinicians for the same reasons as the clear aligners systems, in that they provide in-house orthodontic treatments with a minimum of training. Complaints arise because the expectations of the patients are unmet or that the treatment becomes extended because the case was assessed incorrectly or inadequately prior to the commencement of treatment.



Before



After

The patient's assessment of your clinical success can be diminished if timescales for treatment are elongated or if they have not been told about the need for a permanent retainer

Branded consent forms

it is common for the manufacturer to provide a consent form that is a "one size fits all" and patients make assumptions from this consent document that does not allow for any flexibility in the time that their treatment may take. The practitioners are encouraged by the manufacturer to use consent forms and information leaflets provided by the manufacturer that are not patient or problem specific and may not cover every aspect of the patient's requirements. It is essential to include the specific features of an individual patient and the possible problems that may arise from these features as part of the valid consent process.

Fees

In all aspects of dentistry, fees will be the focus of complaints if a full and complete explanation of the fee structure is not provided to the patient prior to the commencement of treatment. The aligner and short-term plans involve laboratory costs that must be factored in to the costs of the treatment, and it seems to be very common for the patients to pay the full fee upfront prior to the commencement of treatment. The mobile population including both patient and contracted dentists may create another factor in meeting the completion of treatment deadlines when the treatment has been paid for in full, and either the patient or dentist is not available to complete the treatment.

Most specialists provide their treatment using progressive payment plans and are able to use a formula to apportion the total fee based on diagnosis - active treatment - retention components. Any interruptions to treatment will be accommodated by the original and new provider without interruption to treatment of the patient and without a complaint about fees or additional costs.

It is necessary to forewarn the patient of any imminent changes to staffing and to put in place solid arrangements for the continuation of treatment and fees. If the patient is moving prior to the conclusion of treatment, similar arrangements for fees will be necessary as well as a referral to another clinician of similar standing who is prepared to take over the case management. Such events will usually test the quality of the records and the professionalism of the practice.

Dental Protection has a 30 minute interactive module on orthodontic risks. dentalprotection.org/Prism

You can also download resources and guidelines to help you achieve best practice

Dental Protection

ETHICS FOR ALL 2016

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ETHICS CPD

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SATURDAY 01 OCT 2016

PRETORIA

CSIR International Convention Centre
0830 – 1300, followed by lunch

SUNDAY 02 OCT 2016

DURBAN

Durban ICC
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