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YOU CLAIM FOR

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PUBLICATION



UK INDEMNITY, ADVICE & SUPPORT



Welcome to your **SoundBite**

MORE recently qualified members will be familiar with this journal which, for the last seven years, has been specifically designed to inform and support trainees. My illustrious predecessor, Sameera Teli, edited a wide range of *Soundbite* articles, many with particular relevance to readers looking up at the steepest part of the learning curve.

Moving forward, we have decided to expand the scope of *Soundbite*. We have not lost our focus on practitioners in the embryonic stages of their careers. However, there are now articles which, hopefully, will have resonance for all dental members, irrespective of their level of experience.

Having recently spent some time gazing "upstream", the GDC has published its vision of the future and on [page 4](#) Joanne Curran examines the implications of *Shifting the balance*.

At some stage most dentists will consider practice ownership,

and this demands an entirely new skill-set. On [page 6](#) Alun Rees expounds the advantages of having a comprehensive and flexible practice systems manual. On [page 7](#) Alan Frame looks at complaints aired online using public forums, such as Facebook.

Abhi Pal examines some potential problems associated with the provision of implant dentistry on [page 8](#), and on [page 10](#), I look at pitfalls in the labyrinthine regulations relating to NHS claims.

Finally, Kristin Ballantyne talks to Nigel and Vicky Milne, practice owners in Dunoon, who set up a charity that brings dental supplies and treatments to needy patients in Malawi ([page 12](#)). Their selflessness and enterprise is a lesson to us all.

Something for everyone, I hope you will agree.

• **Doug Hamilton**
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SoundBite is published by The Medical and Dental Defence Union of Scotland, Registered in Scotland No 5093 at Mackintosh House, 120 Blythswood Street, Glasgow G2 4EA. The MDDUS is not an insurance company. All the benefits of membership of MDDUS are discretionary as set out in the Articles of Association. The opinions, beliefs and viewpoints expressed by the various authors in *SoundBite* are those of the authors alone and do not necessarily reflect the opinions or policies of the Medical and Dental Defence Union of Scotland.

TOO FEW TODDLER VISITS

AROUND 80 per cent of one to two year olds in England did not visit an NHS dentist in the last year despite the fact that dental care for children is free, according new figures collated by the Faculty of Dental Surgery (FDS) at the Royal College of Surgeons.

The figures also show that 60 per cent of children aged one to four did not have a dental check-up in the same period up to 31 March 2017.

The Faculty believes that there is "widespread misunderstanding" among parents and some health professionals about when a baby should first visit the dentist. Children should have regular dental check-ups starting from when their first teeth appear at around six months of age, according to accepted guidance.

Over 9,200 tooth extractions were performed in 2015/16 on children aged one to four in hospitals in England. Many of these cases can be attributed to tooth decay which is largely preventable through good oral hygiene.

Professor Nigel Hunt, dean of the FDS, said: "In a nation which offers free dental care for under-18s, there should be no excuse for these statistics. Yet we know from parents we speak to that there is widespread confusion, even in advice given to them by NHS staff, about when a child should first visit the dentist."



FGDP (UK) GOING INDEPENDENT

THE Faculty of General Dental Practice (UK) has announced that it is now undertaking the first steps towards becoming an independent organisation.

The FGDP(UK) was established as a faculty of the Royal College of Surgeons in 1992 and in the ensuing years has built a professional home for the general practice dentistry community in the UK.

Early in 2017 the Board of FGDP(UK) announced that it had decided that its aspirations are best served as an independent organisation, whilst remaining in close partnership with the RCS and its Faculty of Dental Surgery. A programme of work has now been developed to prepare itself for independence.

FDGP(UK) has a membership of nearly 5,000 and delivers courses in implantology, minor oral surgery and restorative care. It also publishes the highly respected *Primary Dental Journal* and produces clinical guidelines written by dentists, for dentists.



ENHANCED COVER FOR COSMETIC PROCEDURES



MDDUS members working as general dental practitioners can now enjoy access to indemnity for earnings up to £15,000 gross income from the provision of certain minor cosmetic facial procedures.

This applies to members paying MDDUS a subscription in a "third year" GDP grade or higher. Above this earning level a supplement will apply.

The procedures must be performed personally by the member and include treatment with botulinum toxin and non-permanent dermal fillers in the treatment of facial wrinkles and/or lip enhancement. All fillers must be manufactured to CE standards and consist of highly purified bovine or human collagen, hyaluronic acid gel, calcium hydroxylapatite or Poly-L-lactic acid (PLLA).

These procedures can only be carried out in the immediate peri-oral area, nasal labial folds and elsewhere on the face. The neck is explicitly excluded.

Members are no longer required to be registered with TYCT (Treatments You Can Trust) but to qualify you must be able to demonstrate at least two years post-graduation experience in dentistry and competence to provide the treatments performed, along with management of anaphylaxis and resuscitation. This must include certification of attendance at relevant courses and CPD on a regular basis. MDDUS does not require documents to be sent to us but the dentist must be able to provide evidence in the event of a claim or other incident.

Dentists must also ensure that appropriate protocols are in place for patient assessment, consent and the monitoring of treatment provided, in line with accepted current practice. Premises must offer an appropriate clinical environment and be registered with the CQC or equivalent national body (if required by law), and afford immediate access to equipment and drugs necessary for the treatment of anaphylaxis and for resuscitation.

Contact the Membership Department at MDDUS on membership@mddus.com if you require further information.

ORAL HEALTH IN CARE HOMES

NICE has published a new quality standard covering oral health for adults in care homes. It covers dental health and daily mouth care with and without nursing provision and describes high-quality care and priority areas for improvement.

Over 425,000 people in the UK live in care homes and the new quality standard recommends that residents have their oral health needs assessed on admission and recorded in their personal care plans. Residents should also be supported to clean their teeth



twice a day and/or their dentures daily.

Dr Paul Batchelor, fellow of the FGDP and a member of the committee which developed the new standard, commented: "The degree of oral health provision in care homes is highly variable, but these basic measures – assessing, recording and daily cleaning – could significantly improve the health and quality of life of residents, and should be applied universally."

NICE published a clinical guideline on the oral health of adults in care homes last year, and has also produced a quick guide resource for care home managers on improving residents' oral health. Access the new quality standard at www.nice.org.uk/guidance/QS151.



NEW WEBSITE OFFERS CPD-ACCREDITED LEARNING

MDDUS members can log into our new website to access a wide range of risk resources, including CPD-accredited modules, video presentations, online courses and webinars.

Find out about key dento-legal risk areas such as consent, confidentiality and data protection by visiting the

Training & CPD page at www.mddus.com.

Members can also download practical risk checklists on topics such as duty of candour, clinical dental record keeping and incident reporting, watch video presentations on core risk topics and access our dental documentary *An introduction to practice risks in dentistry*, which can be used as a team training session with the associated discussion guide.

To log in, enter the email address you have registered with MDDUS along with your membership number. For help, email risk@mddus.com

REFORMING FITNESS TO PRACTISE IS A TOP PRIORITY

NEARLY two-thirds of dentists believe that the number one priority for the GDC should be making fitness to practise procedures more fit for purpose, according to a survey undertaken by the BDA.

These findings form part of the BDA's response to the recent *Shifting the balance* document, setting out proposals to reform the GDC (see page 4 in this issue).

Nearly 2,300 dentists took part in the BDA survey which found that 71 per cent wanted to see fitness to practise procedures made more

fit for purpose as the main priority. A fifth of respondents (19 per cent) put the GDC's signature concept of 'upstreaming' – focusing on reducing the likelihood of harm arising in the first place – as a top priority. Ideas involving expansion of the regulator's remit and activities all scored low as priorities.

The survey also revealed the profession appears open-minded about ministerial plans to merge health regulators. Two-thirds of respondents said they would support a dedicated dental regulator, but a similar

proportion would back amalgamation if greater efficiencies could be achieved.

The BDA stated that "significant concerns" were revealed over the Dental Complaints Service (DCS) from those with direct experience of the service and there was support for moving complaint handling away from the regulator – with only 13 per cent supporting a continuing role in this area.

BDA chair Mick Armstrong said: "Dentists want a watchdog that can get the basics right, and that has to start with fitness to practise."

A SUPPORTIVE SYSTEM

The General Dental Council have set out their vision for a fairer regulatory system with a greater focus on prevention. But will it make a difference for dentists?

CUMBERSOME, inefficient and failing to put patient safety at its heart. That is the damning verdict on the current model of dental professional regulation – delivered by none other than the regulator themselves.

The General Dental Council have been subject to sustained criticism from various corners of the profession in recent years, and this latest statement would appear to be some form of mea culpa. The current regulatory model, the GDC say, has become “unsustainable” with “significant change” needed to secure their long-term future.

Their solution calls for a fundamental rethink of how dental professionals are regulated, building on investment and improvements already underway. Their ambitious new programme, *Shifting the balance: a better, fairer system of dental regulation*, was published in January 2017 and the consultation closed in April. It develops a number of themes set out in a 2016 corporate strategy document which detailed how they would become an “efficient and effective regulator”.

This future vision promises a fairer, more focused system where only the most serious complaints are handled by the GDC. This in turn would reduce stress on dentists while putting patients first and perhaps even relieving budgetary pressures. So can it deliver?

Multi-pronged approach

The major theme in *Shifting the balance* is the notion of moving “upstream” (the word appears more than 30 times) which essentially means a move away from enforcement to prevention and partnership

working. This would go hand in hand with more proportionate use of the regulator’s powers, thus saving money by minimising “expensive” enforcement action. Enforcement powers, the GDC say, will only be used when dental professionals put patients at serious risk or damage public confidence in dentistry. They want to “support and empower” the profession and build a more collaborative relationship with the dental team, focusing on a number of different channels to achieve their vision.

Serious cases only

The GDC say many of the issues raised with them could be better resolved by other organisations. In its future vision, they would deal only with the most serious cases while lower level issues would be dealt with elsewhere, usually in the practice or care setting.

The report states: “We want to work with the profession to ensure that resolution is sought and found in the most appropriate place. This involves ensuring patients know how, and feel confident, to raise their concerns by the most appropriate route. It also means working to maintain high standards in complaint handling across the profession.”

Most practices, they say, operate effective complaints handling systems but more work needs to be done to strengthen so-called first-tier complaints resolution. The GDC hope to achieve this through measures such as their profession-wide complaints handling initiative, as well as adding complaints handling guidance into registrant welcome packs. It is also hoped more complaints can be resolved locally by encouraging more patients to complain directly to their practice with the help of an “approachable and welcoming culture in practices”.



While this is a notion many would welcome, its success relies on big changes being made across the healthcare system as the GDC admit "there are limited processes in place to reroute these matters to a more appropriate body."

Building partnerships and education

The success of the regulator's vision relies on improving links with major UK partners like the NHS, professional associations and systems regulators. The GDC hopes these partners will help "embed standards within practice" and "increase our intelligence picture", for example by sharing data showing which standards commonly cause dentists difficulty. The GDC hope to develop methods to link standards to performance management and appraisal. Partner organisations would also hopefully facilitate local complaints resolution, thus lightening the GDC's workload.

Improved education is also an important part of the GDC's future vision, including plans for more meaningful CPD. Research they commissioned in 2011 found "there was very little evidence to suggest that current models of CPD have an impact on the quality of care delivered, performance or competence".

An enhanced CPD (ECPD) model aims to encourage professionals to "take a cyclical approach to their CPD, involving planning, undertaking and reflection, using a personal development plan", all within the same five-year cycle. Under this scheme non-verifiable CPD would be removed and the number of required hours would be cut to 100 for dentists and 75 for most dental care professionals.

The GDC is keen to encourage "professional ownership" of CPD, with their role being a supportive one, "providing data, intelligence and information to assist professionals in determining their development needs." Implementation is not expected before January 2018.

This "professional ownership" idea has broad support amongst the profession according to the May 2017 *Shifting the balance* response document, but with some concerns over practicalities for independent practitioners and dental nurses. Similar support was also reported for the suggestion of peer review processes and interactive CPD which would see greater collaboration amongst registrants.

Fitness to practise

Improving the fitness to practise process is a priority for many dentists, as reflected in a recent British Dental Association survey which found 71 per cent of respondents wanted the process to be made "fit for purpose". The way the GDC manage their processes has undergone what they

describe as "transformational improvements" in recent years, but they admit they are still tied by "some legal constraints".

One improvement measure was the introduction of case examiners in November 2016. They have the power to agree undertakings with practitioners with the aim of reducing the number of cases that proceed to investigation. It is too early to say whether the promised £2 million annual savings will be achieved.

The response report also highlights strong support for an effective self-triage mechanism to help filter complaints submitted via their website, as well as improved education for the public about the regulator's role. *Shifting the balance* states: "Patients raise many issues, concerns, complaints and feedback about dental services for which our fitness to practise powers are not well suited. We need, working with the profession and partners, to develop ways of ensuring that these concerns can be appropriately raised and resolved, by the right body, at the right time and at the right cost."

The GDC also hope to refocus their processes by tightening up their definition of "serious misconduct" and linking impaired fitness to practise more closely to patient risk and public confidence in dental services. They also plan to carry out an "end-to-end review of the fitness to practise process".

Potential benefits

In addition to financial savings and an increased focus on safety, it is hoped the GDC's plan could reduce practitioners' stress levels.

Indeed, MDDUS CEO Chris Kenny believes fitness to practise reform plays a vital role in this. In a statement following the launch of *Shifting the balance*, he welcomed the "ambitious and radical plan" and urged the GDC to implement it swiftly, fairly and consistently. He said: "The often unjustified threat of regulatory action can destroy careers and reputations and lessen public confidence. That serves neither patient nor dentist. We support all steps that will make the complaints and regulatory processes less stressful for dentists and reduce the number of unjustified final hearings."

The potential benefits of the GDC's plan are many and it can only be hoped they find enough support to deliver a regulatory system that better serves dentists and patients alike.

Joanne Curran is an associate editor of SoundBite

SMOOTH RUNNING

SUCCESSFUL individuals and great teams have two things in common: the ability to do the simple things correctly time after time, and the facility to build on the simple so that the complex also works well.

Without doubt, the practice of dentistry has become more complex with associated pressures on professionals. One reason is the increasing sophistication of available patient treatments and another is the rise in technology required in practice. Other elements include the rise in patient demand/expectations plus the growth in the compliance "industry".

We are where we are, the genie has well and truly escaped and no amount of complaining or reminiscing about a return to the "good old days" will get it back into the bottle.

I often ask new clients: "How does your business run?" and I try to provoke them to look at what happens at every stage of the patient's progress through their practice. The phrase "patient journey" trips easily off the tongue yet is rarely looked at in any detail.

My interest in systems was sparked by my Uncle Dave who owned a manufacturing engineering business which produced the "widgets" beloved of MBA case studies. In Dave's case these were steel clips, made by the thousand and sold to large, multinational firms who demanded consistently high quality. All suppliers had to be BS/ISO compliant, which was summed up for me as: "Everything must be of a consistent, repeatable high standard, that standard to be agreed upon by all parties, and documentable".

The consequence in my practice was to encourage every team member to ask the simple question: "Why?" about everything that we did and then: "Could it be done better?"

The next stage was to break down every task into its constituent parts. From answering the telephone through the administration of a patient visit and of course our clinical

Dentist-turned business coach **Alun Rees** looks at the importance of clearly defined practice systems

procedures, we examined, dissected, discussed and rebuilt our processes.

We found large gaps and anomalies as we progressed and the number of presumptions proved revealing. We had always taken pride in being a small team that communicated well with each other and our patients but came to realise that we weren't as good as we thought. As we proceeded with what was an invaluable team building exercise we documented everything to produce our practice manual, the "Practice Red Book", or "How we do things here".

When the practice was sold several years later the new owner showed little interest in the manual, however he later told me how they had used the "red folder in reception" as the basis for passing their CQC inspection.

In many practices that I visit I am told how the practice manager, the head nurse or the senior receptionist "takes care" of everything. The owner is neither sure how things work nor how the systems have evolved over time. They secretly admit that they would be lost without X or Y. They cross their fingers that their key team members are faithful, that they will never get or take a better offer or get bored and want to do something totally different.

If I were starting a practice again, I would also incorporate the work of Atul Gawande from his book, *The Checklist Manifesto*, into practice systems. Gawande explains how to avoid errors without becoming hidebound by bureaucracy.

In these days of routine inspections, most practices have a practice manual of sorts as a file full of the "necessary" forms. Many choose to pay one of the compliance "off the shelf providers" to be kept up-to-date with the legal changes without ever taking full ownership.

So what should a practice systems manual be and why bother writing one?

- It must be a living document, the basis of the administration of the practice and therefore has to be constantly updated.
- Everyone in the business must contribute

and their contributions valued. This will help gain their commitment to implementing policies.

- The writing and reviewing make a great basis for staff meetings.
- The role of all team members is clearly and unambiguously defined.
- By writing a statement of philosophy and mission statement everybody understands what the practice is trying to achieve.
- The induction of new team members is simplified and they can see and understand their role and those of fellow team members.
- It produces improvements in morale and stability.
- All systems are put in place and documented.
- You have clearly documented guidelines and defined standards.
- The improvement in customer service helps to serve your patients better.
- By working smarter, the practice becomes more efficient and is able to work closer to its maximum potential. It saves time, energy, and money.
- Clearly defined systems are essential to avoid conflicts and protect against litigation.
- It marks out your practice as unique.

Further reading:
Start with Why - Simon Sinek
The Checklist Manifesto - Atul Gawande

Alun K Rees BDS is The Dental Business Coach. An experienced dental practice owner who now works as a coach, consultant, troubleshooter, analyst, speaker, writer and broadcaster.
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FROM NEGATIVE TO POSITIVE

What should practices do if they are subject to potentially damaging online comments?

RECEIVING a glowing online review from a satisfied patient can be a welcome boost for hard-pressed practices. But with such positivity comes the inevitable negativity.

The following one-star review (which we've anonymised) recently appeared on Google about the treatment of a teenage patient, apparently written by his mother.

Don't even think about going to The XXX Dental Practice, shower of money grabbing butchers!! My 15-year-old son Darren just had his braces fitted with that idiot Mr B. He obviously doesn't care how much pain he causes as long as he funds his Mercedes. Darren left the surgery crying, with braces cutting his cheeks and big bits of wire sticking out the back! Don't even bother complaining to their sour-faced receptionist Betty. They couldn't give a TOSS about hurting my son who is now terrified! DO NOT REGISTER HERE!!

How could, or should, you respond to something like this?

First, it's important to be aware of the various platforms where dentists and practices can be commented on and rated. Official websites include Care Opinion and NHS Choices, which allow moderated posts and ratings from patients and other interested parties concerning their healthcare experiences - both good and bad. Importantly, the healthcare provider in question has the right to reply to comments, a bit like Tripadvisor, but bear in mind these responses will be monitored by the likes of the CQC.

Unofficial health ratings sites such as "I Want Great Care" provide a similar service and are worth regular monitoring. While not specifically healthcare related, social media sites Facebook and Twitter are massively popular and many dental practices have a presence on one or both. These can be useful for communicating important messages to patients but it may be advisable to ensure privacy settings do not allow patients to post

comments to the practice feed, or that any comments only appear once moderated by the practice.

While you can take steps to control your own social media feed, you cannot fully control what others might post online about your practice. We have seen plenty of examples of extremely derogatory comments which the practice is often unaware of. A search for your practice or a staff member's name will often reveal the extent of any problem.

So if you do come across a negative/abusive comment, how should you respond? This depends on the nature of the comment and whether it is substantially inaccurate and could be considered defamatory/libellous.

One option is simply to ignore the comments as the issue may quickly die down. If you do wish to reply, then you must resist the urge to post an angry rebuke, denial or insult as this will merely inflame the situation. Instead, aim for a more considered response which acknowledges the concern and signposts the individual to the practice complaints/concerns procedure. At all times you must bear in mind patient confidentiality or risk referral to the GDC.

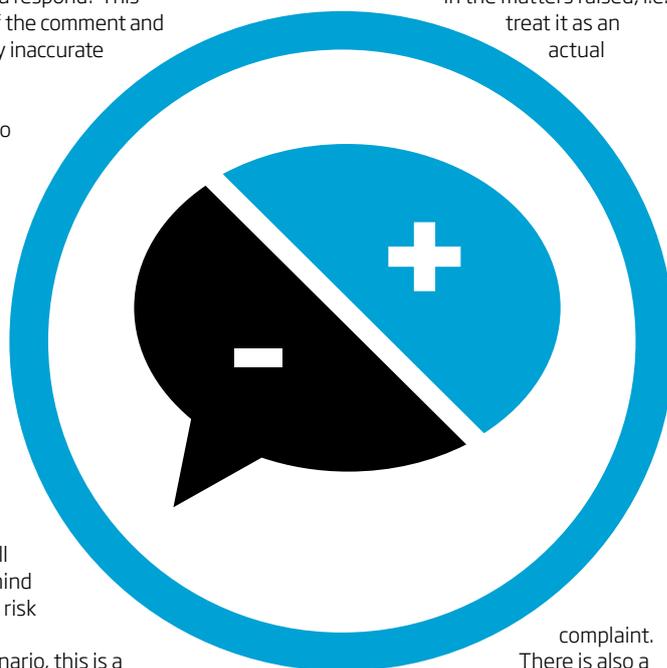
Going back to the scenario, this is a more serious issue as the claims made could be damaging to the practice's reputation. It is not easy to simply ask for the removal of posts you don't like, but social media sites such as Google do have processes in place where users can flag a post and request its removal if they believe it breaches the host site's review policies (e.g. if it is factually inaccurate).

There is also the fact that patient "Darren's" confidentiality has potentially been breached (albeit by his mother). The practice would have to consider notifying the patient about the breach as Darren is 15 years old and considered competent.

Google's own rules state that they will consider removing online information which

breaches an individual's confidentiality, but they would be unlikely to respond to the practice as a third party. This means that the practice obligation is to inform the patient about the potential breach and advise them of the process for having the post removed themselves with Google.

So should the practice respond to the comments and allegations made in the review about Darren's care? One option is to note the content and undertake an internal investigation to establish if there is any truth in the matters raised, i.e. treat it as an actual



complaint. There is also a clear duty of care to

practice staff as their employer to provide support where appropriate to the receptionist who has been criticised.

If the practice decides to respond directly to the post or contact Darren or his mother, this should be done in a professional manner, noting the causes of concern and directing them to the practice's complaints process, perhaps with an offer to discuss and investigate the concerns. Again, be mindful of confidentiality and resist the urge to make angry counter accusations which could end up generating even more negative comments.

Alan Frame is a risk adviser at MDDUS

Dr Abhi Pal highlights key risks associated with an increasingly popular treatment option

MANAGING IMPLANT



RISKS

THE provision of implant dentistry in the UK has been rising for some years and so has the number of patient complaints associated with this treatment modality. This is likely to be related both to the costs and complexity.

Implant dentistry is not yet recognised as a specialty by the General Dental Council, but it is a mode of treatment for replacing missing teeth that does require specific training. The main areas where practitioners face challenges to their care are largely related to competency and training, adequate assessment, treatment planning and consent.

Competency

Dentists contemplating implant training can find more details in the Faculty of General Dental Practice's (FGDP) *Training Standards in Implant Dentistry*. Be sure your course is well structured with an adequate balance between theoretical teaching and mentored clinical experience. The value of mentoring cannot be under-estimated and is the key to ensuring a safe and competent practitioner.

Practitioners whose training pre-dates existing formal courses should be able to demonstrate their training and experience, ideally with a portfolio. Such a portfolio, which should also be maintained by those with formal training, will form the foundation of evidence that a practitioner was competent to undertake implant treatment in the first place. Additionally, a practitioner needs to provide care within their skillset and be aware of when it is appropriate to refer.

Full assessment

Assessing the medical history is of paramount importance. It is especially important to identify smokers, patients with diabetes, patients on medications that affect bone metabolism and bleeding tendency.

The failure to carry out a full mouth assessment and

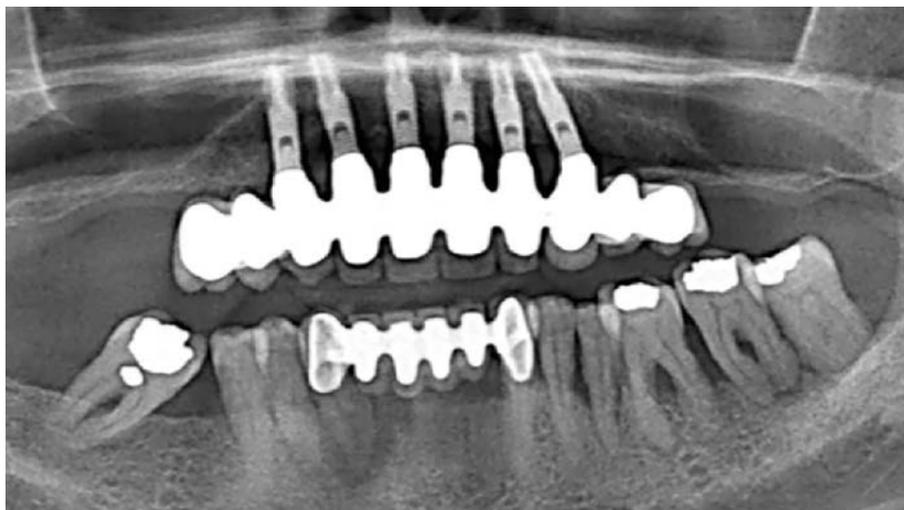
instead focus solely on implant treatment leaves a dentist vulnerable to allegations of poor treatment. This includes addressing caries, periodontal disease and considering the prognosis of other teeth.

Not managing primary disease before embarking upon implant treatment creates the potential for problems further down the line. Patients can become unhappy when they have paid large amounts for implant treatment but then find there were other treatment needs that were not addressed. For example, if an anterior implant bridge was carried out but caries in other teeth were not managed, leading to their early loss, a patient could rightly consider that a different treatment plan would have been more appropriate from the outset.

Periodontal risks

Implant provision in periodontally compromised patients requires particular mention. It is accepted that periodontitis is a risk factor for peri-implantitis and therefore for the failure of implants. It is essential that a proper periodontal assessment is carried out and periodontal care provided that is appropriate to that assessment, before embarking on implant treatment.

The advice given in *The Good Practitioner's Guide* from the British Society of Periodontology is still the accepted standard for periodontal care. If the services of a hygienist are to be used, the dentist leading the care must maintain responsibilities for diagnosing and treatment planning the periodontal condition. Cases involving a failure to adequately manage a patient's periodontal condition before implant treatment can lead to large settlement sums. Post-treatment monitoring of peri-implant tissues is also essential for early detection and management of peri-implantitis. There needs to be a clear understanding whose role this will be in the case of referral patients, since monitoring of these tissues can often become the responsibility of a GDP.



ABOVE: Implant treatment carried out in upper arch without addressing periodontal disease in lower arch. (PHOTO ABHI PAL)

Coordinating care

When more than one practitioner is involved in patient care, it is important to understand who has responsibilities for what aspects of care. Examples are when a patient is referred to another practice for implant treatment or when a patient self-refers solely for implant treatment - or where different practitioners carry out the surgical and prosthetic implant treatments. Without a clear understanding of where responsibilities lie (and in the case of a complaint relating to treatment planning) all practitioners involved in the patient care could become liable to some extent. In the case of different dentists carrying out the surgical and prosthodontic aspects of implant care it is essential that both practitioners agree what is possible to achieve in a particular case, and communicate this to the patient.

Consent

Consent is a vital component of healthcare delivery. In the first instance, valid consent requires that the patient is competent and un-coerced. The patient must also be sufficiently informed about the procedure and alternatives, together with their material risks, benefits and costs.

Alternatives might include bridges or dentures. There might also be a number of implant-based solutions. These treatments must, in the opinion of the practitioner, be clinically justifiable before being placed on the consenting menu.

Risks are those which the reasonable patient in these particular circumstances would regard as significant. Exploration of this issue necessitates bespoke, interactive dentist-patient discussions. Where a highly technical subject is being planned, particular consideration should be given to the comprehensibility of this information. Patients should be given time to reflect on this advice and should be allowed to return with any ongoing concerns.

Written consent for implant treatment is not mandatory,

unless sedation or general anaesthesia is provided. However, I cannot over-emphasise the importance of providing written information, as long as it has been properly drawn up, as a way of ensuring that information has been provided. In order to ensure consent is valid there needs to be patient understanding and therefore I must also caution against solely relying upon giving written information for the purpose of obtaining consent. It is essential that the practitioner spends time in verbally checking that the patient understands the information provided, even if it has been given in writing and allow sufficient time for the patient to consider the information. Furthermore, provision of written information should be as patient-specific as possible.

Part of valid consent is to ensure that the patient is aware of the expected end result. This is particularly important where there is an aesthetic element. Time spent with models, photographs and diagnostic wax-ups at the outset will help to ensure there are no unexpected surprises at the end of treatment.

The provision of a written treatment plan and an estimate of costs is, however, mandatory. This becomes crucial where the treatment is complex with multiple phases, or the plan (and consequently the costs) change during treatment.

Good clinical records are essential to evidence the care and discussions provided. Computer-driven templates are useful in making this process more efficient, but the dentist must ensure that all the information contained in pre-designed templates apply to the individual patient.

Dr Abhi Pal is a GDP who carries out implant dentistry and is currently vice-dean of FGDP(UK). He is frequently called upon by defence organisations, the GDC and clinical negligence lawyers to provide independent expert advice in complaints related to implant dentistry.

"READY TO WALK THE REPAYMENT MAZE?"

SoundBite editor **Doug Hamilton** offers advice on the complex world of NHS claiming regulations

THE treatments offered by our wonderful NHS are many and varied. In most instances care is also free at the point of delivery. One notable exception is NHS dentistry where patients – unless from an exempt group – are presented with an invoice at some stage in their treatment (often leading to hilarious quips about needing more anaesthetic).

The business and the practice of dentistry are not easy bedfellows. Most dentists are motivated by a desire to help patients, rather than ask them for money. However, where a service has been successfully provided, a fee must be paid or funding for future care delivery will dry up.

Resolving disputes

Of course not all treatments proceed as planned. Where something has gone wrong (particularly if this was not anticipated and explained at the consenting stage) then an opening offer of reimbursement or a free remake is often appropriate. Many (although not all) disputes are resolved in this manner.

Where there has been an adverse outcome, compensation over and above the cost of the original treatment may be demanded. Even when the treatment appears to have gone as planned, the patient may look for money simply because their expectations (often in terms of aesthetics) have not been met.

Some members, having sought advice from MDDUS, will stand their ground but many fear the matter could escalate as far as a referral to the General Dental Council – even for baseless complaints.

In these situations, working for a salary without reliance on income from patients can look very attractive. Yet, the self-employed status of most GDPs does offer a degree of opportunity and autonomy. Whilst some opt to work part-time, others work intensively and over long hours in the knowledge that an enhanced salary can be earned.

Clearly, this work rate must not negatively impact clinical standards. Furthermore, within the NHS there are also a significant number of rules

restricting the fees that can be claimed by even the most industrious dentist. These provisos are buried in somewhat opaquely drafted NHS regulations, but failing to comply can have serious consequences.

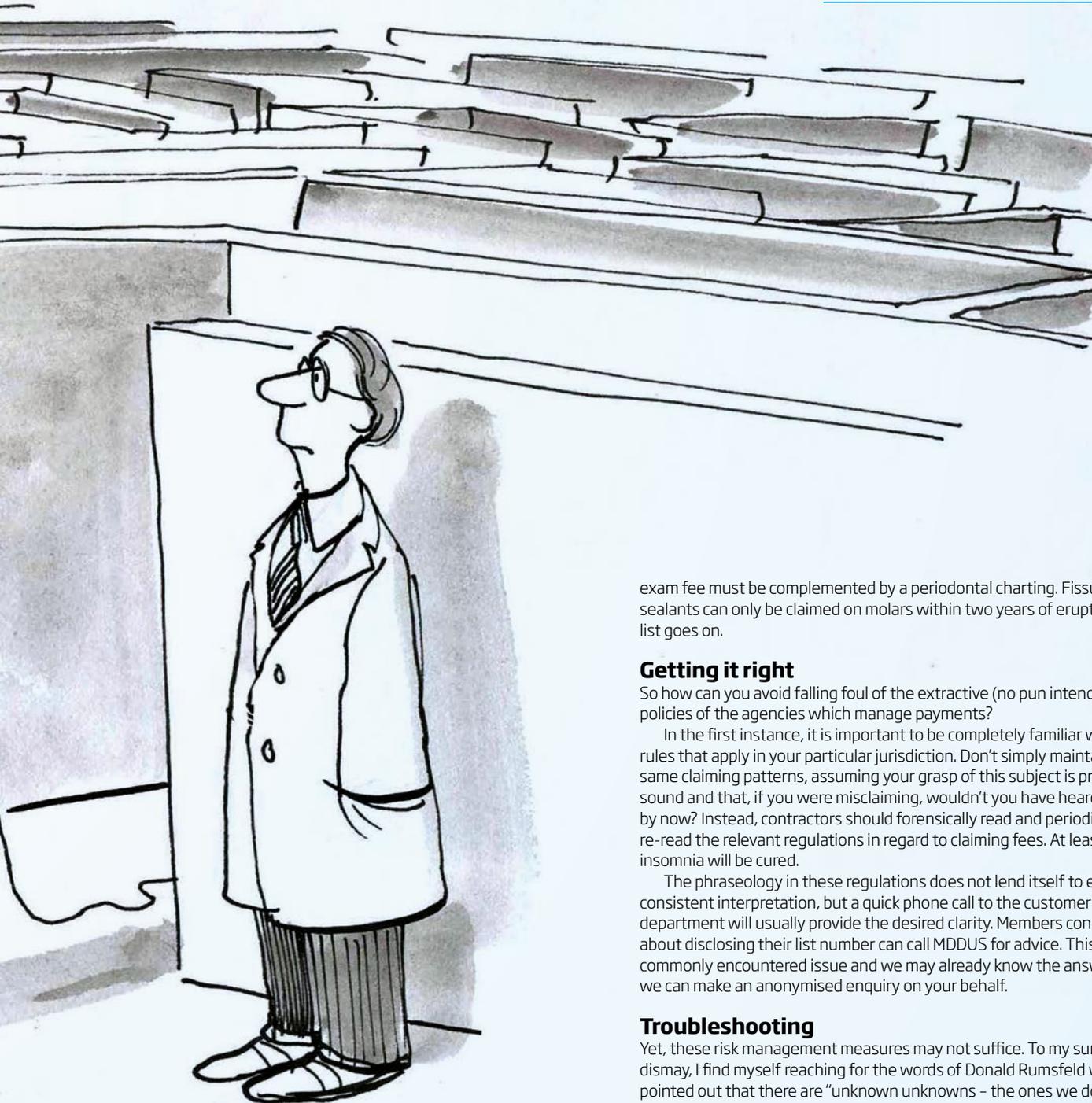
Detecting errors

A number of agencies are tasked with protecting the public purse. In relation to dental payments, this may involve the sampling of records, identification of 'outliers' and statistical analysis. If they find the rules have been broken, however inadvertently, the relevant fees may be recovered.

For associates, it does not matter whether a percentage has already been paid by them to the practice owner. For principals, it does not matter whether a significant proportion of the fees has been expended on laboratory bills, wages, materials etc. It does not matter that both principals and associates may have already paid tax on these earnings. The relevant agencies invariably expect to recover the entire fee. We have found that, in Scotland, superannuation and the GDPA allowance may be added on a pro rata basis.

The sums involved in each misclaim may be pretty trivial but practitioners tend to unknowingly repeat the same error year after year. Once the problem has been detected, the results tend to be extrapolated





and the cumulative fee recovery can be eye-watering.

Not surprisingly, some areas are more prone to misclaiming than others. For example, under the UDA system in England and Wales there are often concerns regarding the commencement of treatment shortly after the previous course was closed. There are of course innumerable reasons why an apparently sound dentition needs to be revisited at an early stage (why do cusps always seem to fall off just after the patient has been finally discharged?) However, where there are repeat claims in rapid succession, the suspicion tends to be that one course of treatment is being 'split' in order to optimise revenue.

In Scotland, the old favourites include item 10b scalings. Yes, the relevant narrative in the Statement of Dental Remuneration can be interpreted in a number of ways. However, its purpose is to ensure the patient receives periodontal treatment (rather than just oral hygiene instruction) on at least two separate occasions (otherwise it would be a two-visit 10a). Of course, the accompanying records and BPE scores should be commensurate with this treatment regimen.

There are many other potential pitfalls. Prescription fees cannot be claimed in conjunction with other treatments (except recalled attendances, domiciliary visits and continuing care payments). An item 1b

exam fee must be complemented by a periodontal charting. Fissure sealants can only be claimed on molars within two years of eruption. The list goes on.

Getting it right

So how can you avoid falling foul of the extractive (no pun intended) policies of the agencies which manage payments?

In the first instance, it is important to be completely familiar with the rules that apply in your particular jurisdiction. Don't simply maintain the same claiming patterns, assuming your grasp of this subject is probably sound and that, if you were misclaiming, wouldn't you have heard about it by now? Instead, contractors should forensically read and periodically re-read the relevant regulations in regard to claiming fees. At least your insomnia will be cured.

The phraseology in these regulations does not lend itself to easy or consistent interpretation, but a quick phone call to the customer services department will usually provide the desired clarity. Members concerned about disclosing their list number can call MDDUS for advice. This is a commonly encountered issue and we may already know the answer. If not, we can make an anonymised enquiry on your behalf.

Troubleshooting

Yet, these risk management measures may not suffice. To my surprise and dismay, I find myself reaching for the words of Donald Rumsfeld who once pointed out that there are "unknown unknowns - the ones we don't know we don't know". It seems reasonable to accept that, if you are completely oblivious to a problem (until PSD come calling), you cannot correct it. Therefore, it is also important to periodically enrol on courses which are designed to troubleshoot, highlighting common areas of misunderstanding so that delegates can learn from other colleagues' misfortunes.

Finally, it is vital that compliance with the claiming directives is clearly reflected in the clinical records. As stated above, enquiries into a contractor's claims can commence with a records card request or, if you are lucky, an instruction to self-audit your records. Contractors have no option but to comply.

Record card investigations have a quality assurance role - poor notes may give rise to concerns about the contractor's performance. However, a review of records may also result in a fee recovery or even a probity enquiry. Comprehensive, accurate and contemporaneous notes are a critical component of safe care delivery. However, dentists should always have in mind the possibility that their records may be scrutinised: not only from the perspective of clinical standards but also as a means of testing the validity and veracity of claims for NHS fees. So make sure your records are compatible with the claim or you may have to hand back your hard-earned money.

Doug Hamilton is a dental adviser at MDDUS and editor of SoundBite

HELPING

Meet the dentists who set up a charity to provide safe dental care to communities in Malawi

THE pile of 500 new toothbrushes is stacked high on the Milne family's kitchen table. As they are both dentists this might not seem unusual, but the brushes are not destined for their patients. Instead the couple will personally deliver them to communities across Malawi.

Practice owners Nigel and Vicky Milne will transport the donated brushes to the poverty-hit African country for Smileawi, a charity they founded in 2015 to improve the oral health of children and adults who don't have access to a dentist.

This will be the sixth time the married couple based in Dunoon in the west coast of Scotland have visited Malawi, a trip which takes the place of their annual summer holiday. Visit number seven is scheduled for September 2017 alongside a small group of volunteers.

The need for help

It all started five years ago with an invitation from John Challis OBE - a patient and founder of Malawi charity the Raven Trust - who had been struck by his experiences there and insisted the Milnes "have to go". So in September 2012, four days after the youngest of their four children left home, they did just that.

Vicky, who has two sons and two daughters (aged 22 to 30) with Nigel, says that first visit opened their eyes to how limited dental care is, particularly in rural areas. "I remember seeing one clinic with just one dental syringe for 600,000 patients, when a practice with a fraction of those patient numbers would usually have 30 or more," she says.

Nigel was amazed to learn that a population of more than four million people in the north of Malawi was served by only 26 dental therapists. Often going unpaid, they struggle to provide treatment with poor equipment and limited supplies of basic materials such as local anaesthetic.

He says: "When we came back, we had two choices - turn your back on it or do something. We instantly felt we have got to do more."

Sugar is cheap

The husband-and-wife team, who met at the University of Glasgow in the late 1980s, have been travelling there at least once a year to carry out much-needed dental care in the main towns and rural clinics where "sugar is cheap and toothbrushes are expensive".

Trip number two happened within a year

along with friend Alan Thomson, a retired doctor and trained anaesthetist. The three of them performed hundreds of emergency extractions in the country where Coca-Cola is the favoured thirst-quencher amongst schoolchildren who do not always have access to clean drinking water.

Vicky says a fundraising drive ahead of their trip allowed them to buy local anaesthesia and two portable dental chairs from international dental charity Dentaaid. Once in Malawi the trio visited three hospital clinics that included dental surgeries, and to rural clinics.

"That's where the real need is," Vicky says. "It is very basic out there and, without electricity or running water, we could really only do extractions and deliver preventative messages. It was such a contrast to come home to a clean surgery with lighting, heating, and running water."

With one in eight people in Malawi diagnosed HIV+, the couple were acutely aware of the infection risk to them and their volunteer dentists and dental therapists.

"We were fortunate to have a safe local anaesthetic delivery system from Astek Innovations which greatly decreased the risk of needle stick injuries," says Vicky. "We were also aware malaria is one of Malawi's biggest killers, but to be honest I was more worried about navigating the transport network!"

Contrasting patients

The couple run the Hollies Dental Practice in the picturesque coastal town of Dunoon, making for a stark contrast between their patients at home and abroad.

Says Nigel: "At home our patients are families and retired people who generally take care of their teeth and have good oral health. That's a huge contrast to Malawi where sugary drinks are often easier to find than clean water, yet most of them don't know that sugar causes dental decay.

"Add to that the fact it's almost impossible for people to reach a dentist, especially in rural communities, and many end up suffering toothache for years."

A busy day for the Smileawi team can see as many as 50 people waiting for treatment. "For us, the main aim is to relieve long-standing dental pain," Nigel says. "But sometimes we don't have time to treat them all and it's heartbreaking to leave them, especially as many may have walked five or 10 miles to see us."



PHOTOGRAPHS: NIGEL MILNE AND KRISTIN BALLANTYNE



Continuing care

Both arriving in Malawi and returning home can be "a huge culture shock" for the couple, but their charity work continues.

The 500 colourful toothbrushes occupying their kitchen table were donated by Dunoon Grammar School and are among a range of vital supplies the Milnes will take with them on their forthcoming trip, including a seventh portable dental chair, bottled water and a Dentaaid water steriliser.

To date, Vicky, Nigel and around 40 volunteers - whom they call the Smileawi family - have delivered hands-on dental treatment, extracting up to 2,500 rotten teeth in one visit. The purpose of this latest trip is to visit and work with each of the 26 dental therapists in their clinics.

They also plan to catch up with their former



"We saw one clinic with just one dental syringe for 600,000 patients"

translator Lusekero Kyumba, a dedicated young man who is training to be a dental therapist at Lilongwe College of Health Sciences. Nigel and Vicky were so impressed with his desire to help people that they decided to fund his studies through Smileawi, helping him secure a permanent post at David Gordon Memorial Hospital on completion of his course.

Vicky says: "It made it all worthwhile when Lusekero's wife asked to speak to us both. She thanked us so much for 'saving her family.'" Nigel adds: "I don't do 'greetin', but I was welling up."

So how do the busy working parents manage to balance their charity work, with running a busy practice, spending time with their children and enjoying the occasional skiing holiday?

Vicky laughs: "Well, our housework never

gets done, and neither does the garden!"

It's clear from meeting the Milnes that this is a labour of love, as Nigel admits: "I wouldn't do it [dentistry] if I didn't love it and I also wouldn't be involved in a dental charity."

"We manage to have a good balance between running our practice and doing our charity work, and that's largely down to Lynne, our practice manager, and our very understanding patients. Many of them have donated to Smileawi and always ask when we are going out next."

Vicky adds: "Our patients have overwhelmed us with their generosity and support. Recently a group of local ladies knitted baby cardigans, so we will take them out with us this time."

Looking ahead, Nigel and Vicky will continue to send Smileawi volunteers out to treat those

in dire need of dental care, before eventually reducing the hours they work in Dunoon and dedicating more time to their charity.

But as Nigel points out, doing 2,500 extractions in one visit is only the tip of the iceberg: "Malawi won't be able to sort out its dental problems in our lifetime, it's unimaginable, so we will do our best to continue to grow the charity."

It is a formidable task but they remain determined and, as their charity slogan says, they hope to help Malawi one tooth at a time.

- To find out more about Smileawi, including how to volunteer, visit www.smileawi.com

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TREATMENT

ROOT CANAL LIKELY

DAY ONE

Ms B attends as a new patient at a local dental surgery complaining of sensitivity in a number of teeth. A dental associate - Mr W - arranges bitewing radiographs and these show gross distal caries at LR6 and caries in a number of other teeth. He advises that LR6 is of most concern and recommends treatment by an amalgam filling, given the size and depth of the caries. Ms B insists on a composite filling as it looks more "natural". Mr W agrees but records his discussion with the patient regarding the pros and cons of composite versus amalgam filling in this particular case.



DAY SEVEN

Mr W places an extensive composite filling at LR6 but moisture control is difficult as there is an excess of saliva and gingival bleeding. Ms B is also phobic and "fidgety" and keeps closing her mouth. Mr W informs the patient that given the extent of the cavity and difficulty of the procedure, root canal treatment (RCT) may be necessary in the future if the tooth does not "settle".



TWO WEEKS LATER

The patient returns to the new dentist and undergoes root canal treatment on LR6 and another appointment is scheduled to carry out further restorations on the other untreated caries.



FOUR MONTHS LATER

Ms B attends a different dentist complaining of pain in LR6. The dentist also notes untreated caries in three other teeth. A radiograph reveals decay under the filling at LR6 and the dentist undertakes the first stage of RCT and the tooth is dressed with Ledermix.

A LETTER of claim for clinical negligence is received by Mr W from solicitors acting on behalf of Ms B. It alleges incomplete removal of caries at LR6 and also inadequate moisture control resulting in a reduced bond in the composite filling causing recurrent caries and chronic pain with later irreversible pulpitis necessitating root canal treatment.

Ms B claims damages amounting to the cost of the RCT in addition to time off work due to chronic pain.

MDDUS obtains copies of the patient notes and all relevant radiographs and sets out a letter of response based on a detailed case report. It is argued that Mr W carried out the initial restoration on LR6 in very challenging circumstances and to the best of his ability - as would any reasonable and competent general dental practitioner.

Moisture control was difficult given the

problems of a phobic patient and restricted access. Mr W used high aspiration, cheek retraction and cotton wool to absorb moisture the best he could. To the extent there may have been a reduced bond this was more likely to do with the extent of the cavity and use of a composite filling rather than amalgam as was advised by the dentist. Amalgam may not be as aesthetically pleasing but it will restore a tooth even in the presence of moisture whereas with composite materials moisture control is essential as bonding is actively to the tooth substance.

In regard to causation MDDUS argues that the root canal treatment could not be the result of any act or omission by Mr W. The patient presented with extensive caries in LR6 and rejected the dentist's advice on an amalgam filling and - on the balance of probabilities - would have thus required root canal treatment

at LR6 in any event.

It is clear that not all the decay was removed in Mr W's restoration of LR6 but it would not be unreasonable to leave some decay on the base of a cavity and appropriately seal it and allow the tooth to heal.

MDDUS sends the letter of response and receives notification that the case is being dropped.

Key points

- Keep records of discussions with patients in support of shared decision making and consent.
- Advise patients of likely prognosis even with adequate treatment.
- Consider being more proactive in advising patients on the "best" treatment option.

OUT THERE

PLANT RELIEF Neanderthals with toothache may have self-medicated using plants, researchers have found. Remains in Spain showed one man with a nasty abscess appears to have eaten poplar, which contains the active ingredient of aspirin. His dental plaque also had a natural form of penicillin, 40,000 years before its discovery. Source: *CNN*



PRICEY MOULD A "holy relic" of medical science has been sold by Bonham's in London for £11,863 - a patch of mould grown by none other than Alexander Fleming 90 years ago. It bears an inscription from Fleming himself reading: "the mould that first made penicillin". However, the scientist apparently often sent out samples of his mould to dignitaries including the Pope and - oddly - Marlene Dietrich.

TAR TEETH Two Stone Age teeth found in Italy and dating back 13,000 years suggest dentists would scrape out cavities, often using stone tools. And rather than filling them, they would coat them with bitumen - a tarry form of crude oil.



FROM THE MUSEUM

In use from circa 1730, this brutal looking "tooth key" proved surprisingly effective in performing extractions compared to earlier methods. The key consisted of a shaft, a bolster and a claw. To pull a tooth the bolster was placed against the root and the claw over the crown. The key was then turned, dislocating the tooth. With no anaesthetic available, the extraction would have been swift.

PHOTO: BDA MUSEUM

CROSSWORD

ACROSS

1. Train network (7)
5. Organ of thought and control (5)
8. Keeps going (9)
9. Draw (3)
10. Opposite of did (4'1)
12. Army leader (7)
13. Uncategorized (13)
15. As played by Miles Davis (7)
17. Root ____ surgery (5)
19. ____ Master's Voice (3)
20. Showed (9)
22. In computing, storage devices (5)
23. Person seized as security (7)

DOWN

1. Sprinted (5)
2. Bed and breakfast (3)
3. Suit (Cockney rhyming slang) (7)
4. Steely Dan song about dental prosthesis (4,4,5)
5. Sink (5)
6. Beyond lunch (9)
7. Hypodermics (7)
11. Costumes (9)
13. Paired (7)
14. Centre of cell (7)
16. As played by Pan (5)
18. Firmly fix or embed in place (5)
21. "A drink with jam and bread" (3)

1		2		3		4		5		6		7
8										9		
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See answers online at www.mddus.com. Go to the Notice Board page under About us.

Questions



MDDUS members can now take advantage of a great new service designed especially for dentists who are just starting out in their career.

If you have questions about what to expect from practice life, need advice on choosing a job or help understanding associate agreements - we can help.

Our new **Early Practitioner Adviser Laura McCormick** is an experienced dentist who will be on hand to offer free educational support and expert insight into working life.



This great new service is provided at no additional charge for MDDUS dental members in Scotland who have graduated within the past five years.

To find out more email Laura on
lmccormick@mddus.com



UK INDEMNITY, ADVICE & SUPPORT