The smart way to protect your career

For everything included in this policy you have certainty of cover - a legally binding promise rather than the uncertainties of discretionary assistance.

YOUR STATUS: EMPLOYED ASSOCIATE PRACTICE OWNER

| Professional Liability Insurance from RSA |  |  |  |
| Civil liability in public and product liability claims |  |  |  |
| Defence costs regarding clinical negligence claims |  |  |  |
| Legal representation |  |  |  |
| Crisis management |  |  |  |
| HMRC personal tax investigation expenses |  |  |  |
| Whistleblowing |  |  |  |
| Loss or damage to documents |  |  |  |
| Vicarious liability |  |  |  |
| Nurses covered against negligence claims on your policy |  |  |  |
| Cover is also available for other clinical practices such as implants. No additional cost for sinus lifts or bone grafts. Cover is available for cosmetic procedures above the lower border of the mandible |  |  |  |
| Advisory, case management and indemnity support from the BDA |  |  |  |
| Case management and dento-legal advice |  |  |  |
| Support with professional disputes |  |  |  |
| NHS contract and performance disputes |  |  |  |
| Intellectual property (IP) disputes |  |  |  |
| Academic and research disputes |  |  |  |
| Advertising and competition advice |  |  |  |
| Reputation management |  |  |  |
| Remediation |  |  |  |
| Associates/employees |  |  |  |
| Quotes are personalised for hours worked and are UK nation-specific |  |  |  |

See policy summary for details of the policy cover and exclusions bda.org/indemnity/policy

Welcome

When I look back at the first year of BDA Indemnity’s existence it’s hard not to be filled with immense pride at what we have achieved but also shocked by the horrors wreaked by “the virus” on the lives of billions of people across the world.

Our small victory in establishing a brand new indemnity offer on 3 June 2019 and attracting several hundred UK dentists to join us pale into insignificance when compared with the impact of the COVID-19 pandemic. Many countries are now emerging from the worst effects of the disease having lost, in some cases, thousands of their citizens.

The economic effects will be profound and the social consequences of being in lockdown for a prolonged period will stay with us for years to come. “What were you doing during the pandemic” will be a question many will ask of ourselves as will future generations. I can safely say the BDA and BDA Indemnity were extraordinarily busy.

Having launched on 3 June 2019, we signed up policyholders at a steady rate and went on a round of talks and presentations around the country. In response to the pandemic, we closed the BDA office in Wimpole Street on 18 March and during lockdown we have been busy providing guidance on risk assessments, record keeping and reducing premiums for dentists no longer working the hours they had been. We are also planning a series of webinars to support colleagues as they return to work.

We have made plain our position on the scope of our indemnity to our policyholders through these fast paced and changing times. The BDA Indemnity team will continue to provide leadership and clarity alongside dentist to dentist occurrence-based contractual indemnity cover.

I hope you enjoy reading this year’s brochure as much as we have putting it together and if you need any more advice or information you only have to pick up the phone or drop us an email. We are here for you and will be for many many years to come.

Dr Len D’Cruz
Head of BDA Indemnity

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bda.org/indemnity
A unique service designed for dentists and dentistry
BDA Indemnity has adopted a fair, logical and transparent approach to assessing and pricing for differential risk.

It is obvious that patients, clinicians and practice owners are directly affected by risk. Dental organisations are similarly exposed; ranging from giants like the NHS, through corporate entities of varying size, down to a single handed practice. But indemnity providers are also in the business of risk and its management, and need to price the risks they are taking on – adequately, appropriately and (hopefully) fairly.

Detailed knowledge and deep understanding

To appreciate the nature and scale of a risk, requires a detailed working knowledge of the relevant field, and a deep understanding of its nuances. This is where the synergy between ourselves, our expert advisors, and our insurance partner RSA really comes into its own, because it enables RSA’s risk assessment and pricing decisions to be better informed. Companies that generalise medical or other experience without fully appreciating how and why dentistry is different, end up revealing their lack of specialised knowledge by charging too much – or too little.

Procedural risk

Some level of risk and uncertainty is expected in medical/human interventions and dentistry is no different. The provision of some dental procedures has greater inherent risks either because of what the procedure(s) involve in a technical/specialised knowledge by charging too much – or too little.

For example, if one dentist works twice as many hours as another, are they necessarily twice the risk? Or could the part-time dentist be a greater risk during the hours that they do work? Is someone placing one implant a year, a better or worse risk than someone placing 500 implants a year?

Most illogical of all is biasing risk (and therefore, price) on the income generated. A dentist could invest heavily in equipment, training, staff and time to improve quality and minimise risk, and pass on these costs through increased fees. Where is the sense in charging that dentist more than one who makes no such investment and can charge lower fees?

BDA Indemnity has adopted a fair, logical and transparent approach to assessing and pricing for differential risk and this has received much favourable comment from those members who have switched across from other indemnity providers.

Individual risk

Assessing the level of risk presented by an individual, is not an exact science. Past experience, such as previous claims history can be helpful, but is not necessarily a reliable guide to future risk. What matters more is an understanding of the complex tapestry of underlying factors that might make the future risk profile better (or worse) than the historic risk. BDA Indemnity aims to be responsible and fair to all members; to minimise the prospect of members with a lower risk regularly having to pay much more favourable comment from those members who have switched across from other indemnity providers.

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For some years now, there has been a lot of noise surrounding the rising cost of professional indemnity and a perceived ‘climate of fear’ in the UK. It’s response included the decision to explore the professional indemnity market and whether or not it continued to serve the needs and best interest of UK dentists.

Over many decades, the main indemnity providers for doctors and dentists in the UK have been the mutual defence organisations (MPS/Dental Protection, MDU/DDU and MDDUS – referred to here as the ‘MDOs’). Over the years they have charged broadly similar subscription rates for dentists in broadly similar work situations. But latterly their paths have progressively diverged and there are now wide differences in what the same dentist might be charged by the three MDOs suggesting that rate variations are driven much more by internal factors within each organisation, rather than by the actual risks they are taking on, or the environment in which they are all operating.

The rapid subscription increases have been attributed to the frequency and scale of dental claims, the exploits of the ‘no win – no fee’ law firms and a decade of GDC dysfunction. This may have had some validity in the past, but logically these factors would impact upon all three MDOs in a broadly similar fashion. There are factors which might explain some degree of variation, amongst other external factors impacting the claims environment. Fig 1 demonstrates an underlying upward creep in dental claims (as in wider society over the same period) but change occurring outside the profession and beyond the profession’s control has had by far the biggest impact on UK dental claims experience in the past quarter century.

Dental Claims
It was Lord Woolf’s ‘Access to Justice’ proposals in the mid 1990s and the ensuing reforms introduced in 1999 that proved to be the first real game changer, ushering in the ‘no win-no fee’ (NWNF) law firms and giving them a decade or more of rich pickings from dentists in England and Wales. During this period, dental claims became more attractive and lucrative for the NWNF law firms and ‘claims factories’ and with the help of proactive marketing these claims became progressively more frequent. Their average value also increased sharply, but this was mostly because of the legal costs being claimed by these law firms (inflated by the ‘success fees’ and other recoveries permitted by the 1999 changes) – patients were not seeing the same increases in the level of damages they received and nor had the standard of UK dentistry fallen.

Clinical negligence claims
Claims against GDPs are generally much smaller in financial value than claims against medical practitioners – and as a result, the associated legal costs are proportionately higher in relation to the level of damages. But the incidence/frequency has historically been quite a bit higher for dentists than for medics. Many factors impact upon all three of the highlighted elements in the resulting equation and this is a dynamic, constantly changing relationship – just as dentistry itself changes and different procedures gain (and lose) ascendancy. Some of these changes increase risk, while others can reduce it. Some types of claim tend to surface quickly while many might elapse before others are reported.

All this needs to be set against the background of an increasingly consumerist society, with greater demands and higher expectations, amongst other external factors impacting the claims environment. Fig 1 demonstrates an underlying upward creep in dental claims (as in wider society over the same period) but change occurring outside the profession and beyond the profession’s control has had by far the biggest impact on UK dental claims experience in the past quarter century.

Then a refreshing outbreak of sanity came in the form of Lord Justice Jackson’s review of the operation of the Woolf reforms, and in particular the management of legal costs in the civil justice system. Unfortunately it took time for the finalised Jackson proposals to be unveiled and there was then a further six month postponement before the final implementation of the Legal Aid, Sentencing and Punishment of Offenders Act (‘LASPO’) – delays which the NWNF firms put to good use by actively marketing for and then stockpiling claims that could be progressed under the more lucrative pre-LASPO fee arrangements. Although LASPO was implemented in April 2013, it was not until 2015 that those stockpiled claims ran dry and the full benefits of the Jackson reforms started to flow through (Fig 3) – a painfully long six years after the publication of Lord Justice Jackson’s Interim Report.

After 15 years of steadily worsening claims frequency following the Woolf reforms, and then a welcome pause while the situation briefly stabilised, there followed a dramatic reduction in the number of low value dental claims involving solicitors, contributing to a welcome reduction overall. The average level of damages has inevitably risen with fewer of the smallest value claims contributing to that average, and also because the NWNF firms have targeted particular kinds of claim of mid- and higher value instead. But importantly, there are still fewer litigated dental claims overall, and while there are continuing concerns over the level of legal costs that the NWNF firms are claiming in the remaining cases3, these costs are in most cases a lot more proportionate than previously. In any event they are no longer inflated by the heavy burden of success fees and various other costs, all of which LASPO has made the patient’s responsibility (payable out of their winnings’), instead of being payable by the defendant dentist. The DDU, for example, reported in 2018 that costs had halved in many of the lower value cases. So not only have the wings of the NWNF law firms and claims factories been clipped at last, after several of them had shamelessly plundered the system for more than a decade, the litigation picture is no longer one of a rapidly worsening dental claims experience – indeed, quite the reverse.

But worse was to come with further amendments to the Dentists Act which led to the smaller council with fewer dentists and (for the first time) a lay chair as from September 2013. These were the ‘meltdown’ years over which the GDC’s reputation hit an all-time low, with its performance attracting the most bitter and vocal criticism from both houses of parliament4, from the GDC’s own regulator the Professional Standards Authority, from the BDA and other professional bodies, and from the profession at large.

Changes in the structure of the GDC and its operation, which began with the Section 60 Order in 2005 to amend the Dentists Act, marked the start of a less sympathetic and more hostile regulatory approach. Concerns grew regarding the extent to which the voice of dentists was listened to and valued, and there seemed to be a lack of focus and proportionality in the GDC’s actions – particularly (but not limited to) its Fitness to Practise (FTP) procedures. By 2010 UK dentists were already more likely to beEventoreated for poor performance or ‘meltdown’ years over which the GDC’s reputation hit an all-time low, with its performance attracting the most bitter and vocal criticism from both houses of parliament4, from the GDC’s own regulator the Professional Standards Authority, from the BDA and other professional bodies, and from the profession at large.

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While most dentists who lived through that period will remember the plentiful horror stories, the future over the GDC's performance, its proposed 46% increase in the Annual Retention Fee, and the BDA's successful legal challenge, for fewer are able to remember – let alone explain – what followed. The GDC was forced to utilise 2013 that 'more of the same' was not an option and that it could within its existing powers and rules to change its approach and begin to address the problems. Further reforms to the Fitness to Practise procedures followed in 2016, and early in 2017 the GDC published "Shifting the Balance", which set out a fundamental shift in the way it operated. A greater proportion of cases are more appropriately directed elsewhere or resolved at lower levels. Only the genuine, most serious cases progress to hearings - which is all excellent news. So while there remain some issues to be addressed, it is important that dentists are not paralysed by an unjustified climate of fear, based upon scaremongering, misinformation and outdated assumptions about how the GDC's FIP procedures are operating.

Other encouraging signs

The dental profession seemed to be under siege in 2012-2016 when the Office of Fair Trading and the Consumers Association were also on the warpath. The tabloid media abounded with 'dentist-bashing' stories, and CQC was arriving on the doorsteps when the Office of Fair Trading and the Consumers Association were also on the warpath. The tabloid media abounded with 'dentist-bashing' stories, and CQC was arriving on the doorsteps of more dental practices. By 2018/19, however, dental practices were acknowledged by GDC inspectors as top of the class amongst the various types of locations where healthcare was provided. This alone should have justified the profession feeling a lot better about itself. By 2019 our Press Office was regularly winning the war of words in the media too, and it is now widely accepted that dentists are not responsible for problems of access to NHS dentistry or overloaded A&E departments and GP surgeries, nor for the consequences of shambolic commissioning of orthodontic services in England. The tide has certainly turned for the better, and hopefully this article restores some perspective and injects greater positivity into an overly fearful professional environment that has been gloomy for much too long.

Consequences

Dealing with a complaint is a testing time. It can be daunting to feel judged and unsupported by the dental team. Dentists can experience shame and fear when telling another team. Dentists can experience shame and fear when telling another family, a spouse or other colleagues they have received a complaint. Isolation is debilitating. Running through the sequence of events and blaming oneself whilst unable to sleep can seriously undermine confidence and lead to a downward spiral of worry. It is easy to forget the importance of an appropriate professional boundary: patients, however friendly, are still patients and not friends. A complaint can undermine a dentist's confidence, leading to doubt in your own abilities and the unhealthy practice of overly defensive dentistry.

Complaints - The hidden 'cost'

Dr Jane Merivale

Money

The fact that eligible patients pay for dental treatment creates a significant difference between primary care dentistry and medicine. Certainly, a lack of clarity about fees is a common cause of patient complaints alongside other communication issues. A refund of fees or a contribution towards remedial treatment may help resolve such complaints; but what about the hidden cost? The refund may have drawn the matter to a conclusion but the long-term cost to the dentist may last far longer.

MOTIVES

It's natural to speculate on a patient's motive in making a complaint. But whatever the motive, dental professionals have an obligation to comply with GDC Standards and respond to the complaint.

Impact

Most patients do not fully appreciate the impact of a formal complaint on a registrant. Regardless of your career to date, it is impossible to predict exactly how any particular clinician will react; a young dentist bumbling with zeal may be just as affected as an experienced dentist. Dentistry is a stressful profession and a complaint can sometimes be the last straw leading to professional burnout.

In-house complaints policy

At first glance the requirement to have a practice complaints policy that invites feedback and complaints might seem counter-intuitive. However, a clear, accessible, user-friendly complaints procedure lets your patients know how and where to complain. It also implies that you care about your patients and the quality of your treatment.

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Avoid harm after hurt
Dr Suzy Jordache

What is a ‘resilient mindset’ and why does it matter?
Meet hypothetical dentists A and B. They are both hurt during professional practice but only one is harmed.
Both dentists receive similar complaints from patients alleging they were rude, dismissive and carried out unnecessary treatment.

Dentist A is upset and confused on receiving the complaint; and goes on to happily practice for many more years.

Dentist B is upset and confused on receiving the complaint; and struggles to continue to practice, eventually leaving dentistry.

Dentist A is described as open, hungry to learn, humble, eager for feedback, rightly proud that his or her knowledge and ability is excellent but aware that much more is required to navigate safely day to day. He or she seeks out role models and new ideas and watches as others balance/bend/fix/learn and grow and cultivates an absolute determination to adapt and thrive.

Dentist B is rightly proud of his or her knowledge and ability and is keen to accept full responsibility for clinical care. In return he or she expects implicit trust in his or her abilities from patients and staff. Being highly conscientious and determined to deliver excellent care, he or she is mercilessly self-critical and does not seek feedback from others. Self-belief and confidence are key ideals to be protected and celebrated. Any challenge triggers painful rumination and is seen as a threat to be neutralised.

Many dentists get hurt during professional practice – hurt by failed expectations, difficult colleagues, rigid systems, ethical conflicts, financial burdens, regulatory requirements, and through complaints and cases brought against them. Some have thrived; others have resigned, gone off sick or continue to practice unhappily.

A resilient mindset does not protect us from hurt; but it can insulate us from harm. It appears to be crucial for career longevity and joy at work.

Reflect on role models
Try to identify your role models – or seek new ones. Tease out their behaviours, values and attitudes that impress. Noticing and naming their flaws can be equally important and challenges our own perfectionist tendencies.

It is also worth reflecting on our own status as a role model. Osamea and Gallagher 2018 noted that good role models in dentistry “exhibit a positive personality”. Emulating and striving to cultivate the characteristics of Dentist A is worth careful thought.

Learn from success rather than failure
Perfectionism and conscientiousness can block a resilient mindset. This has been critical to understanding the vulnerability of clinicians ². Whilst perfectionism is an essential driver of high-quality patient care, it can lead to a closed mindset with a reluctance to delegate and to be relentlessly critical of self or others. For perfectionists, focusing on failure can trigger unhelpful guilt, self-doubt and rumination. Focusing on success and noticing how great results can be achieved despite flaws and omissions, can be transformative.

Cultivating a resilient mindset - prioritising flexibility, adaptability, buoyancy or whatever synonym works for you – is an essential wellbeing management strategy.

Additional reading

1. ‘Black Box Thinking’ by Matthew Syed (ISBN: 97814736313775) explores the evidence for and importance of a ‘growth mindset’.

2. ‘Humility is the New Smart’ by Hess and Ludwig (ISBN: 9781626568754) offers a fascinating programme to cultivate a growth mindset. Chapter 4, ‘Quieting the ego’, works on the need to challenge our own ‘reflective emotional defensiveness’ omissions, can be transformative.

We’ll fight your corner and pay expert fees in investigations and inquiries, GDC and/or disciplinary hearings, tribunals and courts.

A state of mind: Stress and the support available
Dr Roz McMullan

“We can easily manage if we will only take, each day, the burden appointed to it. But the load will be too heavy for us if we carry yesterday’s burden over again today, and then add the burden of the morrow before we are required to bear it.”

JOHN NEWTON 1725-1807

The advice above was written over 200 years ago when, arguably, life was conducted at a much slower pace, but it is still as relevant today. Stress and burnout impact on many people, and we in dentistry are not immune. However, it is not a new phenomenon and epidemiologists working in this field have clearly demonstrated that. There has been some recent subtle variation, but research shows that self-reported stress in the workplace has remained largely unchanged over the last decade and more³.

A certain amount of stress in the workplace can improve performance, but when it exceeds an individual’s ability to cope, it can be very destructive to the entire team. Stress affects the efficiency, empathy and competency of the clinician. Not only can this lead to a very anxious, dithering and unfriendly dentist, but it will also lead to complaints; and not only from the patients.

People are now taking about stress amongst healthcare professionals, and that is a good thing. Talking about feeling overwhelmed is the first important step in reaching out for help. Research tells us that social networking is very effective in combating stress. Often talking in a safe and confidential space with someone who understands, is all that is required to help an individual prioritise and manage their daily tasks. One such space is your local BDA Branch or Section meeting; you will get some CPD as well.

If you are feeling overwhelmed, your local LDC will have a PASS (Practitioner Advice and Support Scheme) scheme, run by fellow volunteer dentists, who can offer practical support and advice. For some, additional professional help is required to support their mental well-being. All members, including students, have access to Health Assured, an assistance programme, for counselling, emotional and debt support and it is encouraging to see members accessing this service.

Other mental health support services are available to dentists in England through the NHS Practitioner Health Programme and in Northern Ireland through Inspire. In addition, the BDA Benevolent Fund does remarkable work on a daily basis, supporting those who find themselves in financial difficulty and the Dentists’ Health Support Trust helps dentists suffering from mental health and addiction problems.

Prevention is the key
Leaders of the dental profession have been working to reduce the causes of stress. To give credit where it is due, the work the GDC is doing with early career dentists to alloy their fears and freeing them up to practise effectively, is showing signs of paying off. In addition, the chances of a registrant reaching a Fitness to Practice committee has fallen considerably, and with the new processes implemented by the GDC, should continue to do so. The GDC still has a long way to go, and the BDA will continue to hold to account the GDC and other regulatory bodies as “light-touch” organisations.

Members of BDA Indemnity have already taken a step to reduce their own stress levels. BDA Indemnity is run by skilled and knowledgeable dentists, ready when necessary, to manage your reputation, and advise and support you through whatever can otherwise be an overwhelming and expensive experience.


3. Dr Jordache is a Dentist/BPA Risk Prevention and Resilience Coach

We’ll fight your corner and pay expert fees in investigations and inquiries, GDC and/or disciplinary hearings, tribunals and courts.

Members can access 24/7 counselling and emotional support to help manage the pressures of dentistry.

Reflection is a powerful tool to think about allegations and demonstrate that any shortcomings, have been addressed by the time an investigation might possibly reach a formal hearing.

A state of mind: The reflective practitioner
Dr Russell Heathcote-Curtis

Readers will know that a process of reflection became part of the GDC’s enhanced CPD requirements as from the 1 January 2018.

What do we actually mean by ‘reflection’?

Reflection is a thought process whereby individuals consider recent experiences obtained from clinical practice to gain insights about themselves and the environment in which they practice. Reflection can inspire and support the individual clinician to continually improve the way they practise dentistry and the quality of the work provided to patients. It is intended as a continuous and routine part of the way that today’s healthcare professionals are expected to work.

The GDC introduced the process of reflection as an enhancement to the CPD scheme with which all registrants are obliged to engage. The enhanced scheme (ECPD) encourages dental professionals to reflect on the outcomes of the elements included in their own cycle of CPD activity, focusing on what they have learned and how this has influenced their daily practice and duties.

The GDC is not prescriptive about the way in which dental registrants should reflect or how those reflections should be recorded – reflection is a process with a different meaning and application for each one of us. There is no suggestion that “one size will fit all”. Professionals are encouraged to use the reflective process in a way that suits them best.

The GDC also provides an activity log template pre-loaded with a series of questions that are prompts to make sure that you have a pathway to follow. You might also have noticed that many CPD providers now include a set of questions to help you to write reflective notes about the CPD you have undertaken.

It doesn’t matter which set of prompts you use but it is important to write down your reflections. These reflective notes are not the same as the sort of notes you might use to record clinical techniques, or to describe treatment options.

Looking forward not back

When writing about your reflections, it is important to address more forward-looking questions such as “did this professional development identify any new learning needs?” and “how will it change the way I work?” These particular questions are quite different from those which ask, “what did I learn?” The forward-looking approach provides you with an opportunity to demonstrate insight into any learning needs that you discover and how that could improve the care you give to patients.

Reflection is slowly becoming a more common practice among dental professionals as more colleagues familiarise themselves with the process and share with others the improvements they have introduced in their practice and the services provided by their dental team.

For example, on a very simple level improvements introduced after an episode of reflection could demonstrate how patient feedback and complaints have been listened to and acted upon. By making changes in the practice, you will also assure patients that the dental team engages in a continuous learning cycle.

There is no standard format for a reflective log and there are many templates available and you can, of course, use a structure created to suit your own style. You could keep reflective logs of all your personal development and not just lectures you attend. This will include reading of guidelines, refereed papers, lectures, workshops, online CPD, observation sessions and peer review with colleagues or auditors.

Showing willing

We’ll work with you to create a personalised plan to avoid regulator sanctions.

A state of mind: Collegiate support
Dr Len D’Cruz

Working in primary care dentistry can result in some dentists feeling isolated. Even if you work in several practices you may not see any other dentist colleagues during the day as they are busy with their own patients. Some people come and go to the surgery without any meaningful contact with their peers, other than a perfunctory good morning and goodbye.

It doesn’t have to be that way of course, but like any other relationship it requires the people involved to invest time, trust and unconditional respect for one another.

Case scenario

An associate dentist saw a patient with pain in the lower left quadrant. The patient’s mouth was heavily restored and several teeth in that quadrant were tender to percussion and slightly sensitive to cold air. None of these tests enabled the dentist to determine exactly which tooth was causing the problem but the LL7 was the more likely candidate. The patient was going away on a two-week holiday and wanted the problem fixed. With the patient’s consent, the dentist extracted the LL7 having given the patient all the options. The extraction was uneventful.

That sinking feeling

A week later, the patient sent an email to the practice from America saying that his pain had persisted and that he had been to an American dentist who had extirpated the pulp of LL6 and the pain had now gone. He finished the email with a warning to an American dentist who had extirpated the pulp of LL6 and America saying that his pain had persisted and that he had been to an American dentist who had extirpated the pulp of LL6 and the pain had now gone.

He had extracted the wrong tooth and he was certain he had extirpated the pulp of LL7 instead. He had extracted the incorrect tooth.

Naturally, when the receptionist brought in a copy of the email the associate’s first reaction was that there was a change in his mood. He had extracted the wrong tooth and he was certain he was going to be sued or a complaint lodged with the GDC. He spent the rest of the day worrying about it, not really concentrating on his list of patients. He looked at the notes and radiographs and now thought he could see a widening of the ligament around the LL6 which he thinks he might not have seen on the day. He became more convinced he had carried out the wrong treatment; chastising himself for not extirpating the pulp rather than taking it out.

He thought he would respond directly to the patient apologising for the pain he had experienced and inviting the patient to come in to discuss the matter. There was no response to the email, and he began to panic, worrying more and more and imagining extreme scenarios.

A supportive team

Fortunately, the dental nurse picked up on his anxiety and distracted behaviour which inhibited his engagement with the patient and members of staff. The nurse spoke to a more senior dentist who raised this with the practice owner.

Together they sat down with the worried dentist and discussed the case. They agreed that the dentist had acted reasonably in the circumstances and that they would have done much the same, faced with the same clinical scenario. It was only when the dentist was able to think about the case rationally, cutting out the emotional noise, that he was able to contextualise the issue.

When the patient returned from holiday, he attended a meeting at the practice. The associate along with the practice owner carefully explained the diagnostic dilemma faced by the associate and once this had been explained and understood the patient decided not to pursue the complaint.

A problem shared

There is a recognised ‘shame response’ after receiving a complaint. Dentists feel unable to share their mistakes with others, fearful of being seen as incompetent or worried about being judged by colleagues.

Any dentist who has treated patients for a reasonable period of time will have made mistakes, missed something they should have seen or provided treatment that was less than ideal. The important thing to remember is the impact that a complaint can have on an individual.

The timing of the delivery of complaint can also be important. Handing the dentist a complaint letter at the start of a busy treatment session will inevitably affect their focus and concentration. There is also a risk that the news will affect the state of mind of the dentist for the rest of the session. It would have been far better to discuss the matter at lunchtime or at the end of the day when the dentist could find time to review the records and discuss this with other colleagues in a more relaxed and controlled manner.
The joys of a portfolio career
Dr Len D’Cruz

You might think that a portfolio career was just a millennial phenomenon that results in young professionals actively choosing not to work in a 9-to-5 job in the same place every day. A career based on a portfolio of professional activities has in fact been around for decades. Although, in the past it may have been driven largely by the economic imperative of making a living, rather than for personal development and fulfillment.

For example, generations of teachers have supplemented their income by providing personal tuition or evening classes. General nurses have undertaken agency work at weekends to support their household income, along with legions of other workers.

Equally, the portfolio dental careers chosen by dentists have also been around for many years, but it was “baked” as a career pathway for general dentists who were faced with staring at the same four walls of the surgery for the next 40 years, unless they were provided with an early release (retirement) for good behaviour.

Dentistry: the job for life

Those putative escape routes included joining the Local Dental Committee, the local BDA branch section or a Young Dentist group. From there the dentist could move onto paid jobs by taking on the role of a vocational trainer, tutoring for a dental deanship or teaching undergraduates. All those roles still exist but dentists will now need to adopt a well-considered strategy and a well-considered strategy to choose not to work in a 9-to-5 job in the same place every day. They fell into other professional roles, many more by luck than design.

The received wisdom is that many colleagues in today’s dental workforce are unlikely to spend their entire professional career in one industry, let alone one organisation. If that prediction holds true, there would be a terrible waste of time and money invested in qualification and registration, by prematurely leaving the profession - unless you really hated every aspect of it.

Top tips for developing a portfolio career

1. Try before you buy. Use the early years of your career to explore different aspects of dentistry. Unless you try something beyond your normal comfort zone you won’t know if you might enjoy doing implants, orthodontics or cosmetic dentistry for example. If you want to write, be sure you have published articles before you make the leap.

2. If you feel training, education and lecturing is your forte, give it a go. Volunteer your skills to your local BDA section, postgraduate centre or teaching establishment and get feedback on your performance. You might think you are good, but have great wisdom and wit to share but no one else does!

3. There is no single magic job out there. Different jobs and workplaces provide different experiences and incentives. However, you are unlikely to find a job that offers your ideal salary, enchanting and inspiring work colleagues, opportunities for growth, creativity and unbridled happiness. Accept that as a fact, work out where you can compromise or stay where you are.

4. Think “continuation” not “escalation”. This is what Michael Greenspan talked about in his blog for Harvard Business Review. It is a peculiarity that dentists doing consultancy work at the height of their career are probably earning less on a daily rate than they could by working in a practice treating patients. The joy of a portfolio career lies in discovering a new synergy in different aspects of dentistry. Your expertise and knowledge in one area spilling over into the other, enriching both your personal experience and the organisation you are working for. Making a connection between disparate elements of dentistry makes you a unique asset.

5. The work-life balance. Ironically this might be the first casualty of a portfolio career. Throwing yourself into a new part-time role can become all-consuming if it eats into your spare time, weekends or evenings. Your family and a social life can be affected if these commitments involve nights away and time spent in preparation. You need to be selective and organised – more organised than you ever will by doing one job. You need the ability to say no, politely and firmly.

Tooth whitening
Dr Lorna Ead

The domination of social media continues. At the end of 2019, Instagram alone could boast almost 24 million UK users. This has fuelled an increased awareness of self-image and the quest for the elusive perfect selfie has impacted on the demand for cosmetic procedures, including tooth whitening.

As with any elective cosmetic procedure, careful patient selection and their valid consent is vital. A signature on a generic information leaflet can be a useful adjunct to the consent process, however, it is only the detail of the discussions, recorded in the individual patient’s clinical notes, which really evidence consent.

Changes to the tooth whitening legislation were implemented on 31 October 2012, reflecting an amendment to the EU Directive 76/768/EEC. Brexit is unlikely to affect the key points summarised below:

1. It is illegal for tooth whitening products which contain more than 6% hydrogen peroxide to be used for cosmetic procedures. Products containing or releasing between 0.5% and 6% hydrogen peroxide, can only be sold to dental practitioners. 16% carbamide peroxide products are permitted as they release less than 6% hydrogen peroxide.

2. The dentist must first carry out an examination of the patient to ensure no concerns about their oral condition. This should also be kept in mind when advertising tooth whitening or considering it for offers or prize donations.

3. The first cycle of each use must be undertaken by a dentist or by a suitably trained and competent dental hygienist, dental therapist or clinical dental technician, if under direct supervision of the referring dentist, and an equivalent level of safety is ensured. BDA Indemnity recommends the prescribing dentist to be present on the premises.

4. Products releasing between 0.5% and 6% hydrogen peroxide cannot be used on those under 18 years of age.

It is the role of Trading Standards and the Health and Safety Executive to enforce the legislation; the GDC has made it clear that it will refer any information on a breach of the regulations. In addition, they will consider the possibility of a criminal offence when reviewing a registrant’s fitness to practice, irrespective of a prosecution.

The High Court case of GDC v Jamous confirmed the GDC’s position that tooth whitening is “the practice of dentistry” that is only legal when provided by registered dentists. It will pursue criminal proceedings against any person found to be illegally practising dentistry, irrespective of the concentration of the product used, including products containing less than 0.5% hydrogen peroxide.

In order to carry out tooth whitening responsibly, the dental practitioner must first undertake an oral examination of the patient in registered premises.

Under 18

The restrictions on tooth whitening in patients under the age of 18 years has created a dilemma for dentists if they consider the restriction not to be in the best interests of a particular patient. The GDC considers tooth whitening to be a cosmetic procedure rather than the treatment or prevention of disease. It is anomalous that the destructive preparation of an immature tooth for an indirect restoration, sits within the confines of the law, whereas an internal bleaching procedure is not.

On those occasions when you want to use hydrogen peroxide to whiten a tooth in a patient under 18, it is important to record the consent process in detail. This should reflect the discussions with the patient/parents/next of kin, ensuring full information on the risks and benefits of whitening procedures and the alternatives; together with a discussion about the legal status of tooth whitening procedures. The notes should make it entirely clear the extent to which the discoloration of the tooth is creating a problem for the patient, meriting your intervention before they reach the age of 18. It is advisable to contact your indemnity provider for advice in these situations. Members who contact BDA Indemnity for advice and support can be reassured of full and ongoing support.


Whitening is considered a dental treatment so it’s covered in our policy - there’s no additional cost.
Connecting with patients
Dr Jane Merivale

We live in an era of readily accessible information and instant communication, but in the process we risk reducing the quality of our connection with others, including our patients. The more time we spend communicating with tablets and phones, the greater the chance of becoming de-skilled when meeting people face to face.

Have you ever had a conversation that left you feeling that your views and ideas had been listened to and understood? It is worth reflecting on what made that interaction so good because in doing so it is possible to identify the skills that were needed. Now transfer those skills to the dentist-patient relationship where good communication really matters.

Time spent with patients is limited and research confirms that by honing our communication skills, we can increase patient satisfaction and thereby reduce our dento-legal risk, whilst at the same time, by forming a stronger therapeutic alliance, patient compliance is improved and so are treatment outcomes.

Focus of attention

Good communicators are in touch with their feelings and can control that inner dialogue. By setting aside these feelings and filtering out distractions, the clinician becomes fully aware of their patient. Such focused attention creates an essential space for active listening. When a patient is in the dental chair, they are the most important person in the room and the focus of your attention is one way to demonstrate that.

Observation

A wealth of information is gained in the first few minutes of a consultation - on greeting, look the patient in the eye, and observe their facial expression and body language, all of which provide non-verbal clues about how the patient is feeling. At the same time, observe yourself. Employ open, friendly body language. Gesture where the patient should sit and if possible, sit with your face at their eye level. Watch the patient as they speak and lean slightly forward to demonstrate interest and respect.

Prosody

This linguistic term describes the rhythm, tone, pitch and loudness of our speech. It is the intonation we use rather than the actual words we say, that conveys a feeling of being cared for. Research has demonstrated that untrained, non-clinicians can predict a clinician’s litigation history with 75% accuracy simply by listening to a consultation, hearing only pitch and tone, no words. It's not what we say, but the way we say it that matters.

Memory

Making a beneficial connection with your patient requires asking insightful, interested questions at the right moment (not interrupting) and listening to the answers and remembering them. Dentists are trained to listen for symptoms when the patient speaks, but it is also important to listen for any unspoken emotional emphasis attached to what they said. None of this is possible if we are buried in our computer screen, or with our back to the patient.

Clarity

“A wealth of information creates a poverty of attention”

Whilst providing patients with the information to make decisions and provide valid consent, we may inadvertently default to ‘transmit’ mode and overwhelm them with information that leaves them “paralysed”. We can probably recall occasions when we've been given masses of information at high speed before being asked to make a decision, when we really want to say: ‘what do you think?’

We cannot make paternalistic decisions for our patients, but we need to be selective and clear in what we communicate, to help patients navigate and understand the information they need to hear to make informed choices.

Top tip

Avoid over-complicated, unfamiliar technical terms and instead, mirror words the patient has used to describe their symptoms and expectations. This technique helps the patient to feel we are on their wavelength. After communicating information about treatment, summarise what has been said and ask the patient to confirm their understanding before adding the summarised précis to the clinical record.

Fulfilment

‘No man is an island’

Human beings do badly when isolated from others and need to be part of a community in order to thrive. Dentistry provides such a community and at the end of their career, most practitioners say that it’s the people they miss rather than the job itself. Face to face conversation has to flow in both directions if the clinician is to create a connection with the patient. This in turn creates a sense of fulfilment in our career, particularly as the connections with patients are reinforced when they return to see you again.

Vicarious liability
Dr Kevin Lewis

The ‘Perspective’ article on pages 6-8 summarises the far-reaching legal reforms that were introduced in April 2013, which forced a group of notorious ‘no win-no fee’ law firms targeting dentists, to search for new ways to replace the income they had lost as a result of the legislative changes.

One of their favoured tactics is to allege that the owner of a dental practice is vicariously liable for the negligent acts and omissions of any member of staff working in or for the practice – even if the person who carried out the treatment was a self-employed associate dentist.

Put simply, the well-established legal principle of vicarious liability means that an employer can be held responsible for the negligent acts and omissions of an employee. There is an assumption that there is an element of control, direction, oversight and supervision that comes with the relative power, seniority and authority of the employer. In short, the employer makes the rules and the employee follows them. The employee is integrated into the employer’s organisation and has very little autonomy and independence.

Over time, the courts have come to recognise that modern working relationships are often not a true employer-employee relationship at all. But each court is free to decide whether or not a particular working relationship, however it is described contractually or intended to operate, is ‘akin to employment’ and whether the owner of a practice has an over-riding duty of care owed to all patients treated in the practice, that cannot simply be delegated to a third party – even if it is that third party who actually treats the patient.

The greater the level of control exerted by the practice owner and the more unequal the balance of power and freedom to act independently of any decisions, the more difficult it becomes to deny that such a duty of care, and vicarious liability, exists. Some dentists, who carried out the treatment may have left the UK and/or is no longer registered, and untraceable for the purpose of pursuing the claim. In addition, the situation could arise that a dentist has no access to indemnity (or was refused indemnity), so the ‘no win-no fee’ law firms have a strong financial interest in giving themselves a second bite of the cherry. So they are increasingly targeting practice owners in addition to (or sometimes, instead of) the associate, and often stating unequivocally - and incorrectly - “As practice owner, you are directly liable for any negligence of any clinical staff at your practice, regardless of their employment status.” One has even asserted that “practice owners are now responsible, and potentially legally liable, for treatment provided by every associate they employ, and have ever employed, including those who have long since departed from their practice.”

The policy covers you for acts or omissions of practice colleagues for whom you are vicariously liable.

1 The Legal Aid, Sentencing and Punishment of Offenders Act 2012 (LASPO)
2 Lewis K; Vicarious Liability; BDJ In Practice Vol 32, Issue 4: April 2019
3 baas.org.uk/Indemnity

Some of the ‘no win-no fee’ firms will start to run these speculative vicarious liability arguments against practice owners from the very earliest stages in case correspondence, even when the associate who treated the patient is known to have their own indemnity. This is not just a belt and braces’ strategy; it less obviously creates an opportunity for the claimant’s solicitors to generate significant additional fees from over-working these preliminary arguments, perhaps invoking more than one indemnity provider. Obviously high legal costs have sometimes been claimed using this ploy and this compounds the pain for any practice owner who has discovered that they have no cover for vicarious liability claims and the associated costs, which can be considerable.

Social justice

In some recent cases, the courts have clearly found it unacceptable that a deserving claimant be denied access to compensation properly due to them, simply because of the associate and practice owner’s working, contractual and indemnity arrangements. In one recent case the further question arose of whether, as a principle of social justice and public policy, it was right that the NHS and NHS bodies should be able to walk away from any responsibility for dental services that they had elected to commission, leaving the practice owner(s)/provider(s) and performer(s) to carry the can.

Summary

A potential and growing risk certainly exists for practice owners, whose indemnity may or may not cover vicarious liability. BDA Indemnity was designed to eliminate this uncertainty and meet this new threat head-on. Further background and practical advice can be accessed from the website.
The provision of dental implants in the UK continues to rise with many more patients accessing the implant option for the replacement of missing teeth. This increase means that many more patients require appropriate follow-up and maintenance for dental implants in order to minimise the risk of longer-term complications.

One challenge that has been well documented for clinicians is the implant complication of peri-implantitis; a chronic inflammatory process affecting both the hard and soft tissues around dental implants. It presents a growing medico-legal challenge for the profession in the UK due to the progressive bone loss that occurs and can commonly lead to the loss of the implant.

The prevalence of peri-implant disease appears to vary widely in published dental literature from 6% to 30%, with a common presentation of peri-implant bone loss at around six to eight years after placement and restoration. The pathogenesis of peri-implant disease follows a similar course to periodontal problems around natural teeth, although it is well recognised that the two disease processes are distinct.

The initial soft tissue inflammation around implants, termed ‘peri-implant mucositis’, is regarded as a reversible stage where active intervention and management can prevent progressive bone loss occurring around the implant fixture. When the inflammation progresses to bone loss around an implant and the development of the established lesion, this is termed peri-implantitis. It is therefore essential to identify and manage peri-implant mucositis at that early reversible stage to prevent the commencement of bone loss around the implant fixture.

Risk factors
A number of risk factors have been identified that may predispose patients with dental implants to peri-implantitis. These include poor hygiene around the peri-implant tissues, cigarette smoking, type 1 diabetes, sub-optimal implant placement, non-keratinised gingival tissue and a past history of cigarette smoking, type 1 diabetes, sub-optimal implant placement, non-keratinised gingival tissue and a past history of cigarette smoking.

Diagnosis and monitoring of implants
The diagnosis of peri-implantitis is usually made by a combination of clinical and radiographic assessment. Clinical findings around implants with peri-implant disease may include soft tissue inflammation, bleeding on probing (an important marker of risk) and occasionally there may also be suppuration.

It is therefore important that pre-existing implants are assessed both clinically (including probing of the peri-implant tissues) and radiographically as part of routine oral health examinations.

Clinical assessment of healthy implants can normally be expected to demonstrate healthy non-inflamed peri-implant mucosa and the absence of bleeding on gentle probing. Peri-implant disease is commonly asymptomatic for patients in its early stages and so can go undiagnosed until an established lesion has developed with progressive bone loss around the implant fixture.

Radiographic assessment will usually show evidence of bone loss around the top of the implant and sequential radiographs can be compared to those taken previously to assess any changes in the bone levels occurring over time. It is accepted that healthy implants should maintain stable bone levels after the first year of service (bone remodelling around implants usually occurs in the first year after restoration) with bone loss of less than 0.2mm per annum thereafter, although this figure is clearly difficult to assess due to variations in alignment of intra-oral radiographs. It is also important that, if GDPs undertake screening using bitewing radiographs that show dental implants with evidence of bone loss, further intervention is offered to the patient. This may involve periodical assessment of the implant to fully ascertain the extent of the bone loss as well as the option of referral for further management to the provider of the implant, or an alternative clinician with the experience to assess and manage the implant bone loss.

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A significant challenge for General Dental Practitioners is the responsibility to monitor implants for their patients that may not have been provided by themselves. The advent of dental tourism and the provision of implant treatment in overseas clinics, as well as patients accessing treatment with other clinicians has further increased this occurrence. There is the potential for a disconnect between the practitioner who has the responsibility for the dental health of a patient but who did not provide the implant treatment, and the clinician who did.

From a medico-legal perspective it is important that all clinicians ensure that patients are made aware of the need to monitor and maintain dental implants with appropriate clinical and radiographic follow-up, as well as advising appropriate hygiene support (ideally this should be raised with patients as part of the consent process, prior to provision of dental implant treatment).

Many patients do have a regular follow-up with the clinician who provided implant treatment but not all of them. Possibly, the patient’s regular GDP may not wish to maintain implants or feels that they do not have sufficient experience. In these cases it is imperative that patients are offered and advised to seek regular review and maintenance from another clinician who is able to monitor and manage any subsequent complications with the implants.

In clinical practice where patients may not see the dentist at every visit (such as direct access for hygiene treatments) patients should be encouraged to have a yearly review of their implants with an appropriately trained clinician, who can undertake clinical and radiographic assessment of the peri-implant tissues.

Regular follow-up of patients with dental implants is the only way to ensure early diagnosis of peri-implant complications and offers the opportunity for preventing progression of the disease. If it can be identified at the early peri-implant mucositis stage. Such prevention also requires the maintenance of a high level of specific and focused oral hygiene by patients.

Management options
The treatment of peri-implant infection focuses on the management of the infected lesion, decontamination of the implant surface and, ideally, an attempt at regeneration of the lost hard tissue resulting from the inflammatory process. It is still not clear as to the best way to manage peri-implant disease as treatment options can involve both surgical and/or non-surgical options, and the current clinical data suggests that the management of peri-implantitis is unpredictable and an ongoing challenge in restorative dentistry.

From a medico-legal perspective it is important to ensure that patients undergoing dental implant therapy have appropriate follow-up both clinically and radiographically. It is important that any peri-implant mucositis or more advanced peri-implantitis is appropriately managed. The early diagnosis of any peri-implant problems can help to prevent these lesions from progressing.
The stability of the condition should be noted along with any risk factors (e.g. smoking status and relevant systemic conditions). Assessment of tooth-by-tooth prognosis can be helpful at this stage.

Inform and document

Recording that you have told the patient they have gum disease is mandatory. Patients often allege they were never informed about their periodontal disease or its severity. Only by recording details of your discussions and recommendations (including quitting smoking) can you challenge such an accusation.

Treatment options should be explained - including any risk of failure and tooth loss, and possible side effects including post-operative recession and tooth sensitivity. Patients need to appreciate that they have an important role in managing their periodontal condition. It is worth noting that failure to comply, despite advice being given, can adversely affect possible future claims of negligence made by such patients.

Diligent home plaque control measures, regular hygienist visits and quitting smoking are important pieces of information that need to be clearly delivered. The BSP leaflet “Periodontal Health for a better life” is available to complement your own advice.

Treat or refer

Patients should be involved in their own treatment decisions. The plan should record whether the condition will be managed within your practice or via referral to a specialist periodontist. BPE codes 0, 1, 2 and 3 are generally manageable in general practice.

The Code 4 and 4* pathway should include the suggestion of referral to a periodontal specialist. If the patient declines your suggestion of a specialist referral, it should be noted.

If the condition is to be treated by your own dental hygienist, they will need a detailed treatment plan including time intervals between formal reassessments. Prescriptions for local anaesthesia can be provided at the same time.

Monitor

Follow-up assessments of the periodontal status can be good for motivation. Susceptible patients benefit from regular reassessment.

Patients may have periods of stability and then deteriorate if home plaque control slips, systemic health deteriorates or if the patient starts smoking again. The onset of diabetes should also be considered if unexplained deterioration occurs.

Summary

By following the advice above, you can help patients manage their periodontal problems.

Effective communication, empathy, thorough periodontal examinations, effective treatment and record keeping are the keys to success.
Dealing with the unexpected
Dr Lorna Ead

Several years ago, a dentist could work in a practice where, on most days, there would be several emergency appointments. These were often squeezed into an already packed diary with very little time to provide a definitive treatment. On too many occasions, the patient was given a prescription and rebooked. This would no longer be acceptable, indeed, if it was then. Inadequate planning meant the dentist who wanted to help their patients had insufficient time to follow best practice guidelines.

A planned and tested system for dealing with dental emergencies is essential for the smooth running of any practice. The plan will vary, depending upon factors such as patient numbers and the population demographic, but it must work for you. It might mean allocating a slot for emergencies each session; providing a welcome cup of tea in the event it is not required.

Once you have accepted responsibility for a patient, you have an ethical and contractual (in the case of NHS patients) obligation to ensure the patient has access to emergency dental care and understand how this can be obtained. The GDC is quite clear on this.

Standard 1.2.4
You should manage patients’ dental pain and anxiety appropriately.

Standard 2.3.9
You must provide patients with clear information about your arrangements for emergency care including the out of hours arrangements.

The importance of planning for emergencies

The absence of a planned approach creates stress that can affect your well-being and subsequently the delivery of care to patients. The absence of a planned approach creates stress that can affect your well-being and subsequently the delivery of care to patients.

Out of hours appointments can impact scheduled patient arrangements for emergency care including the out of hours arrangements.

The management of emergency appointments is an inevitable aspect of dental practice. The ability to diagnose and alleviate pain is hugely rewarding and can be a great practice builder.

Communication and education of our patients is important; following a difficult extraction, a patient informed of the likelihood of post-operative discomfort and advised on appropriate analgesic is less likely to return to the practice as an emergency because their expectations have been managed.

External factors may also impact on how the patient perceives the urgency of their problem (for example, an impending holiday or wedding) and one should be sympathetic to this.

Use your reception team

It is crucial that reception staff can triage and recognise an urgent need; conversely, sympathy and reassurance may well change a patient’s perception that need to be seen straightaway.

If an emergency appointment is offered and refused by the patient, a note should be made in the patient records alongside any advice provided. This can serve as evidence of the practice attempting to accommodate the patient, in the event of a complaint.

The Scottish Clinical Effectiveness Programme offers sage advice on managing dental emergencies, dividing them into three categories and offering general advice on how to deal with each category.

Patient charges

It is the dentist’s responsibility to ensure the patient is informed of the costs of an emergency appointment and for any necessary follow-up care.

NHS contractors need to understand when it is considered appropriate to claim an urgent course of treatment. Outliers are likely to attract the unwelcome attention of the Dental Practice Board.

Out of hours

All practices must have arrangements for out of hours cover and the practice answerphone should provide clear details of these arrangements. This may include an emergency clinic based at a local hospital, or shared cover between a local group of practices. A system should be in place to ensure any notes made at an out of hours appointment are transferred to the next treating dentist, to enable continuity of care.

Summary

The management of emergency appointments is an inevitable aspect of dental practice. The ability to diagnose and alleviate pain is hugely rewarding and can be a great practice builder.

Alignment: Talking clear and straight
Dr Kevin Lewis

The use of orthodontic aligners in clinical dentistry is certainly not new; the underlying techniques have been used for over half a century. The option to use clear aligners should be considered alongside more traditional removable orthodontics and alternative techniques including other types of aligner (for example, Inman).

In the past 15 years, several factors seem to have converged:

• Consumer behaviour and the demand (especially from adults) for the correction of minor orthodontic irregularities that previously might not have received orthodontic intervention.
• The desire for the orthodontic intervention to be as inconspicuous as possible and also to take as little time as possible – hence the heavy marketing of these techniques as ‘invisible orthodontics’ and claiming to dramatically reduce treatment time from two years to six months or less.
• The fact that orthodontic aligners are less obtrusive and usually felt to be more comfortable in the mouth, and can be removed at mealtimes and for cleaning, makes them a more attractive ‘fit’ with the social life of many adult patients, especially when compared to fixed orthodontic appliances.
• The rapid growth in companies offering clear aligner products and services in response to consumer demand, aided by developments in materials science and computer aided design and manufacture (CAD-CAM). These companies invest heavily in promoting their products and services in all forms of popular media as well as within the profession.
• Many of these products are promoted on the premise that general dental practitioners can use them without any specialist training, knowledge or experience in orthodontics, because the treatment planning is undertaken by other ‘experts’ on the dentist’s behalf.

Here in the UK, a further driver has been the fact that clear aligner orthodontics (CAO) is generally provided on a private basis, and is a lot more profitable than many kinds of NHS dentistry. Many patients presenting themselves for CAO also request tooth whitening and other forms of private treatment.

For an orthodontic specialist, clear aligners simply represent just one of many treatment options for them to consider and use in appropriate circumstances. For many general dental practitioners, CAO may well be the only form of orthodontics they provide, all other cases being referred to an orthodontist.

It is striking that the overwhelming majority of complaints and litigation relating to orthodontics, and CAO in particular, arise not from the orthodontic specialists, but from the general dental practitioners when using these same techniques.

With this in mind, we have produced an advice booklet which is aimed primarily at non-specialist GDPs with no additional postgraduate qualifications or higher training in orthodontics, although it is intended to highlight where and why dento-legal problems tend to arise in the use of CAO, whilst also explaining some of the risks of these techniques and how they can be minimised and managed. While aimed at those who are working out in the field of CAO, some of the advice provided (topic areas summarised below) will be equally relevant to those with more experience of CAO.

Potential sources of dento-legal problems

In addition to complaints and negligence claims, orthodontics has been climbing up the leader board in terms of cases coming to the attention of the GDC. The recurring issues in CAO cases tend to include:

a) Training and competence in the techniques
b) Case selection, diagnosis and treatment planning
c) Managing patient expectations, co-operation and compliance
d) Patient information, choice and consent
e) Interproximal reduction (IPR)
f) Compliance with Medical Devices and other legislation
g) Records
h) Dealing with complications and dissatisfaction
i) Retention, long-term stability and relapse.

Summary

It is possible that future developments in the field of CAO – especially in terms of intra-oral scanning, CAD-CAM and 3D/4D printing – may reduce risks and increase both predictability and the range of tooth movements that can be carried out. Further developments may introduce new risks, which it will be important to understand and manage.

For those non-specialist GDPs starting out on the use of these techniques, the safest approach is to keep up to date and be alert to the level of risk. Seek training from a recognised and authoritative source, take your time and start with simple cases; rather than becoming over-ambitious and over-confident.

Unless you are quite sure that a patient is suitable for treatment using CAO, seek the opinion of a specialist or a more experienced colleague. Work with an established company that provides high quality training and support and ideally, access to mentoring.

1. NHS England – Standard General Dental Services Contract – July 2018
2. NHS Business Services Authority Dental Handbook
3. Guidance on.DateField
5. GDC Standards for the Dental Team – www.gdc-uk.org

References

1. Advice on Dental Provision of Fixed Treatments – NHS England
3. Guidance on.DateField

Aligners: Talking clear and straight
Dr Kevin Lewis

The use of orthodontic aligners in clinical dentistry is certainly not new; the underlying techniques have been used for over half a century. The option to use clear aligners should be considered alongside more traditional removable orthodontics and alternative techniques including other types of aligner (for example, Inman).

In the past 15 years, several factors seem to have converged:

• Consumer behaviour and the demand (especially from adults) for the correction of minor orthodontic irregularities that previously might not have received orthodontic intervention.
• The desire for the orthodontic intervention to be as inconspicuous as possible and also to take as little time as possible – hence the heavy marketing of these techniques as ‘invisible orthodontics’ and claiming to dramatically reduce treatment time from two years to six months or less.
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An inspector calls
Dr Lynn Stephens

Completely out of the blue a practice received a visit from two police officers requesting a copy of a patient’s dental records. A patient had been reported missing and the records were needed “in case they found a body”.

The dentist
We probably understand the dentist’s duty of confidentiality, both legally and professionally, but how does it apply when the police are insisting that they are entitled to see the records in such circumstances? Is a missing person investigation different to a criminal investigation, or a request for records to identify a body?

The patient
Patients are entitled to request a copy of their dental records, and to give permission for the records to be provided to a specified third party. The request can be made verbally or in writing. Under the General Data Protection Regulations (GDPR) records should be disclosed within a month. We are no longer allowed to charge the patient for the cost of making copies unless the request is “manifestly unfounded, excessive, or repetitive”. But if a person is missing or deceased, they are clearly unable to give consent and the police are likely to be pushing for prompt disclosure.

The Coroner
Once a body has been found, the Coroner becomes involved. Identification using dental records might avoid creating additional distress for a family member. A Coroner’s request for records to assist in identification is a court order (Coroner’s Court), with which you are legally required to comply. The Coroner will ask the police to collect the records. If the police do not provide a written request you should call the Coroner’s Office for confirmation.

Requesting police help
You may disclose information to the police to assist in the prevention and detection of crime. You are entitled to bring a crime to the attention of the police even if the individual suspected of involvement is a patient. For example, when reporting a theft from the practice, it could be necessary to provide details of potential witnesses - possibly patients who were in the waiting area. Ideally the patients concerned should be contacted to obtain their consent. The minimum information necessary should be disclosed; simply a name and address.

The police ask for your help
If the police are requesting patient details as part of an investigation into a crime, you must consider the seriousness of the crime and the potential danger to the public when making your decision to disclose any information in the absence of a court order. Suspected terrorism or suspected abuse of children or vulnerable adults are likely to have a public interest justification. A report of a missing person is not necessarily a criminal investigation and likely would not justify disclosure of a patient’s records. Disclosure would not prevent a crime occurring, nor would there be any certainty that the particular patient’s body would be found.

When there has been a major disaster such as an aircraft crash, the names of the passengers on board will be known. Victims of a fire or natural disaster such as a tsunami might not be located until well after the event. In such circumstances the police might request the records of the passengers and persons who were known to be in the vicinity of the tragedy, as there will be multiple fatalities to be identified. Disclosure might also be considered to be in the public interest in these circumstances.

GDG Standards Guidance 4.2.1 requires that patient information is kept confidential, even after they die, but is qualified by 4.3.1 which allows that in exceptional circumstances you may be justified in releasing confidential patient information without their consent if it is in the best interests of the public or the patient.

When possible, you should encourage the patient to either release the information themselves or give you permission to do so. You must document the efforts you have made to obtain patient consent in the patient notes. If that is not possible or practical, you should get advice from your indemnity provider before releasing the information.

A ‘never event’ case scenario
Professor Ian Mills and Dr Priya Chohan

This case scenario demonstrates how the dental team can learn and improve the safety of dental treatment following a ‘never event’. Your indemnity provider should be alerted at an early stage so that they can support you in the follow up to the error.

What happened
A 14 year old female was referred by a dental colleague (GDP1) to an orthodontist within the same practice. The patient attended for initial assessment and a provisional treatment plan was proposed. Six months later, the treatment plan was finalised, including a change to the planned extractions. The orthodontist documented the change of plan in the patient notes on the computer, but did not amend the original charting.

The patient booked two separate appointments with another dentist at the same practice (GDP2) for the extraction of four premolars under local anaesthetic (LA). The patient attended for extraction of two premolars on the left side with a plan to complete the extractions 10 days later. At the first appointment, the upper left first premolar (UL1) and lower left second premolar (LL5) were removed. After an uneventful recovery, the patient returned for treatment on the right side.

GDP2 checked the patient notes and identified a discrepancy between the teeth charted for extraction and those requested in the referral. It became apparent that the UL4 and LL5 had been extracted on the first visit, instead of the UL5 and LL4.

GDP2 immediately informed the mother and patient and apologised. Advice was sought from the orthodontist whilst the practice manager and owner were also informed. The orthodontist confirmed the error and explained that it would not impact on the long-term outcome. A full explanation was given to the patient and mother. The mother accepted the explanation and agreed to proceed with the right side extractions as planned.

GDP2 contacted their indemnity provider and a significant event form and a review of incident was instigated. The patient subsequently continued their orthodontic treatment using a fixed upper and lower appliance as originally planned.

Main contributing factors

• An unidentified discrepancy between the notes and charting detailing the teeth to be extracted.
• The orthodontist’s failure to update the charting when changing the planned extractions.
• A software anomaly made it difficult to change charting when the planned treatment was altered.
• GDP2 was working in a new environment using a computer with unfamiliar software.
• A relatively inexperienced dental nurse (trainee).
• Dentist and nurse were unfamiliar with the accepted internal referral process.
• The patient had been seen by five dentists at the same practice over a four-year period, due to recruitment challenges.

Patient/parent impact
The long-term impact in terms of orthodontic treatment was negligible; however, the incident had the potential to cause unnecessary stress for the patient (although in reality, this was not the case). The length of the orthodontic treatment could have been extended.

Review of incident

• The error was identified at an early stage and dealt with professionally and appropriately.
• GDP2 informed the patient and parent and once the error was recognised a full disclosure was made.
• The practice management was informed at an early stage and a Significant Event Analysis conducted.
• The system improvements identified and shared learning within the practice will reduce the risk of repeating the error.

Lessons learnt

• Discrepancies between the notes and charting can create confusion resulting in the wrong tooth being treated – staff must be alert.
• Charting alone cannot be relied upon: clinicians must read the notes.
• A universal Local Safety Standard for Invasive Procedures (LoCSSIP) reduces the risk of extracting the wrong tooth.
• A simple and robust internal referral process can reduce error but only if there is an induction process for staff that covers these protocols.
• Work as a team, staff members need to feel empowered to question decisions.
• New or inexperienced colleagues need to be able to access support when needed.
• Staff should be paired, taking experience into account.
• Without adequate induction, staffing changes have the potential to impact on patient safety.

Immediate changes implemented

• Staff asked to check the charting against the notes - particularly for elective extractions.
• The internal referral process was reviewed and a protocol agreed for referrals between clinicians, with a check to ensure that the charting and the notes were consistent.
• Implement an agreed LoCSSIP for extractions.
• Information about this particular ‘Never Event’ was shared at the next practice meeting.
• The software company was contacted regarding the charting anomaly.

We’ll be the point of contact and manage cases. We’ll liaise with lawyers and experts on your behalf.
Inter-professional disputes
James Goldman

The cost of legal disputes between professional dentists can and does run into tens of thousands of pounds; sometimes hundreds of thousands. In almost all cases, that money is spent fighting over something from the past, rather than constructively moving forward into the future. Litigation is horrible and stressful.

Avoid disputes in the first place

Whether we are talking about business partnerships or associateships, regular discussions can help avoid disputes. Regular clinical audits and peer review should allow dental professionals to identify problems early on, allowing them to be rectified before the “decay” spreads.

Raising a problem

Many people prefer you to raise a problem directly with them. This gives them a chance to solve it.

Clinical problems are difficult. A question around a dentist’s clinical ability is often seen as an attack on them as a person. Many people will struggle with that. The way you raise a concern can help to reduce that feeling.

GDC standard 8.2.3. states: “Where possible, you should raise this right away, before the problem becomes bigger.” This gives them a chance to solve it.

Be open-minded about any comments made about you by a professional colleague. Seek specific examples that you can review. Consult a trusted colleague if you are not sure whether to trust the person raising the allegations. Conversations like this can help you evaluate the evidence and understand the concerns being raised.

Be aware that the biggest problem can be a lack of insight. In most cases, if someone raises a problem, they want to be heard and they want the problem fixed. Will an admission and remedial action lead to a better outcome than mounting a futile defence?

People who raise a problem may not always do this in the best way. Try not to let the delivery of the message dilute the significance of the message itself. Others may raise problems in a way that is not always constructive. Try not to let the delivery of the message dilute the significance of the message itself. Others may raise problems in a way that is not always constructive.

Resolution

Disputes are usually expensive and protracted. If you want to bring it to an end and move on you must talk to your opponent. Be aware that the biggest problem can be a lack of insight. In most cases, if someone raises a problem, they want to be heard and they want the problem fixed.

More importantly, you need to listen; it is best to listen rather than listening to reply.

Consider mediation as a way of resolving disputes. The parties in dispute must discuss the problem in a constructive way to reach agreement. In most cases, neither party is entirely happy with the outcome, but they can both live with it and move forward constructively.

Are you the problem?

Many BDA members contact our advisors when allegations have been made about a poor standard of work. Few admit there could be a problem or that the allegations could have been raised without malice.

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A letter from the GDC

The GDC has a statutory duty to ensure that dental professionals have the necessary skills, knowledge, character, and health to practise safely and effectively. Any suggestion that one or more of these attributes is questionable, has to be assessed and, if necessary, further investigated through the Fitness to Practise (FtP) process. Dentists should be reassured that the number of complaints made to the GDC has decreased significantly from a peak in 2014 and there have been considerable improvements, which are still ongoing, to the FtP process.

Nevertheless, it can be a devastating moment for any dentist who opens an unexpected letter from the GDC informing them that they are about to be the subject of an FtP investigation. The team at BDA Indemnity understands that the reaction to such a letter can be very mixed and frequently includes panic, frustration, anger, disbelief, despondency and fear.

Take heart

Although a few hundred registrants are investigated by the GDC every year, very few dentists are ultimately erased from the register. GDC statistics from 2018 suggest that only 15% of all concerns raised with the GDC eventually result in referral to a FtP hearing, usually a Professional Conduct Committee. In only 12% of those hearings is the final outcome one of erasure - and a significant proportion of those erasures are DCPs.

A review of recent GDC FtP outcomes shows that ensure is often, though not always, the outcome when dishonesty is proven. When the issues are clinical it is much more common for the dentist to be allowed to remain on the register but possibly with restrictions requiring them to undergo supervision or education to improve their clinical skills.

Have you received such a letter?

Should you be unfortunate enough to receive notification of an investigation it is important to read the correspondence carefully and contact your indemnity provider as soon as you can for support and advice. At this early stage it is unusual for the GDC to merely provide details of what it is investigating, but if the patient records have been requested it is likely you will have some idea of the background to the dissatisfaction. You will also be asked to confirm your indemnity, and working arrangements, when you provide the dental records of the patient who raised concerns.

Our experienced dento-legal advisors will ask those with BDA Indemnity to send all this information to them in the first instance, together with a copy of your personal development plan and a list of any recent CPD that you have undertaken. This information provides the advisory team with an insight into any potential weaknesses - so they can advise you how these might be mitigated, perhaps by undertaking further targeted CPD or audits. It also enables the advisory team to assess whether the case is likely to progress and, hopefully, provide reassurance in this regard. Your dento-legal advisor at BDA Indemnity will send the requested information to the GDC on your behalf.

Once all the relevant information has been received by the GDC it will be assessed further, with input from a clinical advisor if the concerns raised are of a clinical nature. If the concerns are considered sufficiently serious such that patient safety is at risk, or public confidence in the profession could be damaged, the case will progress for consideration by a GDC case examiner. In 2018 fewer than half the cases progressed to this stage.

The case examiner stage

This is the first opportunity for the dentist to put their case forward. BDA Indemnity will instruct a solicitor to draft a letter on your behalf responding to the allegations raised. The most common allegation made against dentists are that they failed to provide a satisfactory standard of care. Almost without exception allegations of this type are linked with allegations of inadequate record keeping.

Although many of the cases which progress to a FtP hearing have clinical allegations, these usually either relate to multiple patients, or have an additional element relating to the personal behaviour of the dentist, such as having misled the patient, or acted dishonestly in the process. Few complaints relating to the treatment of a single patient now progress beyond the case examiner stage of FtP.

Dental social media has certainly raised awareness within the profession about some of the eccentric allegations made by the GDC against dentists in recent years. Fortunately, common sense has finally prevailed and, generally, it is now only serious cases that progress to a hearing.

Receipt of an unexpected letter from the GDC is far less likely, and far less of a threat, than it was five years ago.
The benefits of occurrence-based indemnity

The three mutual discretionary organisations (MDOs) which collectively indemnify more than 75% of UK dentists, have all traditionally offered occurrence-based indemnity. This means that if at the time you treat a patient or if an incident occurs, you are paying a subscription that is appropriate to the nature and full extent of your involvement in dentistry, you are entitled to request assistance from that organisation. This can include the granting of indemnity against some or all of any associated costs - such as any damages paid to a successful claimant together with their legal costs and any legal costs involved in representing/defending you. Crucially, your entitlement to request an indemnity continues even when your membership of the organisation ceases, or is temporarily suspended/deferred (for example maternity leave and career breaks); it continues in perpetuity for any clinical challenge arising from dental treatment provided during the period of membership – effectively, for ever.

It should be said here that any assistance and indemnity granted by an MDO is at the absolute discretion of the organisation: you are entitled to request it, but not necessarily to receive it. The advantages and disadvantages of discretionary indemnity are described elsewhere¹.

The most common alternative to an occurrence-based indemnity arrangement is called ‘claims-made’. This kind of indemnity is generally the preferred offer by insurance companies. In its simplest form you can buy claims-made indemnity for a single given year, covering only treatment provided or events taking place in that year and also reported indemnity for a single given year, covering only treatment provided or events taking place in that year and also reported. In its simplest form you can buy claims-made indemnity for a single given year, covering only treatment provided or events taking place in that year and also reported.

Insurance and legal expenses

In our research into the UK indemnity market, it became clear that concerns were being expressed in high places – not least, the Government – about whether or not discretionary indemnity remained appropriate in today’s healthcare environment. The Government’s stated preference², supported by the GDC, was to move towards a model which required all professional indemnity for healthcare professionals to be contractual, provided by regulated insurers rather than on the MDO’s traditional unregulated discretionary basis. As far as cover for clinical negligence claims was concerned, we recognised that an insurance-based model was the best way to ‘future-proof’ members against the uncertainties of enforced future changes.

In addition to clinical negligence

UK dentists also face challenges from the GDC, CQC, NHS bodies, employers and others which may require legal representation. In the UK, legal expenses insurance cover is almost always offered on a claims-made basis. But we knew that in dentistry, the same events often lead to a clinical negligence claim and GDC investigation running in parallel, and it would impede the support of members and smooth management of those cases if one part of a member’s cover was occurrence-based, and the other part was claims-made. Fortunately, that potential impasse was resolved in constructive discussions with the insurers, resulting in a seamless policy covering the whole of dentistry and other risks that dentists might face, all of this being occurrence-based and delivering the added security of a legally binding and independently regulated contract.

As if all this were not complicated enough, retroactivity and run off may attract additional premiums, or may not be offered at all. In addition, special conditions may well apply to a claims-made policy in some commonly-encountered situations, creating unexpected gaps in cover. A surprising proportion of UK dentists who purchase claims-made indemnity can unwittingly find themselves without indemnity, and in breach of the GDC’s requirements. We publish Advice³ to help members to make informed choices, whether or not they choose BDA Indemnity.

Our approach

PRICING

Tell us:

• Where in the UK you work
• If you place or restore implants
• Whether you work full or part time
• If you do any crown-induced work
• If you are within five years of qualification.

You’ll get a quote and if you like the look of it you can apply. Tell us a little more about your practising history then we’ll give you a final price.

Before renewing, take five minutes to get your quote

bda.org/indemnity

Excellent provision and support for a good fee.

A Aviss-Monro

INDICATIVE PRICES

Example prices for members are provided as a guide only. Complete the short online form for an indicative quote for cover.

A precise quote for your consideration will be given upon application and acceptance.

<table>
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<th>Routine work</th>
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<td>THREE DAYS per week</td>
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<td>ROUGHLY EQUIVALENT TO</td>
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Our indicative quotes are intended to give members a broad indication of the possible cost of indemnity cover. They are based on limited information and are not binding or guaranteed. The final purchase price of indemnity cover may differ from the indicative quote.

Indicative prices shown include Insurance Premium Tax and/or VAT where applicable.

2. BDA advice. Professional Indemnity: November 2018, reviewed April 2019
3. Appropriate clinical negligence cover: A consultation on appropriate clinical negligence cover for regulated healthcare professionals and strengthening patient recourse. Department of Health and Social Care. Published: December 2018
4. Response by the GDC to the Consultation on appropriate clinical negligence cover for regulated healthcare professionals and strengthening patient recourse. February 2019
What’s covered:

- Comprehensive indemnity for damages and legal costs - £10 million limit on claims arising from any single policy year
- Vicarious liability for the supervision, training and mentoring of others and for the actions of people working in your practice
- Defence costs including those related to GDC matters
- HMRC personal tax investigation cover
- Defamation cover
- Botulinum toxin, whitening and fillers covered above the lower border of the mandible
- Cover for implants if required
- Compensation for colleagues attending claims hearings on your behalf
- Report writing
- Publication of articles
- Good Samaritan acts
- Providing volunteer dental services abroad for charitable organisations
- Reputation management
- Cover against negligence claims for nurses

For full policy benefits and limitations, please go to bda.org/indemnity/policy

About the BDA

We bring dentists together, support you through advice and education, and represent your interests. We now provide a comprehensive indemnity policy designed specifically for members.

As a trade union and professional body, we represent all fields of dentistry including general practice, community dental services, the armed forces, hospitals, academia, public health and research.

We are owned and run by our members and all our income is reinvested for the benefit of the profession.

How to apply

bda.org/indemnity

Complete the short quote form online. The indicative quote is sent to your inbox.

↓

Like what you see?

↓

Complete the online application form. We’ll review and provide a final price.

↓

We’ll call you to set up the Direct Debit*.

↓

You’re protected

* You may need to upgrade your membership at this point.

About our policyholders:

91 %
switched from a traditional mutual defence organisation.

They switched because

- The nature of the cover is occurrence-based and not discretionary
- It includes things they expect without hidden or additional costs
- Of the BDA’s reputation
- It’s cheaper than their previous provider’s

I felt that my previous indemnity provider did not have my best interests at heart. This was coupled with the ever-increasing fees with only the possibility of cover at their discretion.

A Towlerton

Reasonably priced, clear guidance and reputable advisors.

R Moore

As a member and indemnity policyholder you’ll have the most comprehensive protection available.

BDA Indemnity offers a level of cover that satisfies dentists, patients and now meets better the regulators mandate. The BDA Indemnity small print stands up to the scrutiny the ‘big 3’ are not able to match.

A Pradgan

I have Expert membership and as a practice owner, I have found the membership invaluable. The BDA have been very helpful, and I felt that this would be the case for indemnity as well.”

R Hassan

The BDA provided everything that my previous indemnity organisation did but at a much more reasonable cost.

G Bureau