

Dentistry

Special supplement

Dentistry's guide to dental defence in association with the DDU



Foreword

by Julian English, Executive Editor, Dentistry

We live in an increasingly litigious age, so it's no surprise that dental claims are also on the increase in terms of both frequency and cost. Today, dental professionals can expect to receive a complaint or claim at least once in their career.

However, this is only one of the pressures facing the profession as dentists are also under increasing scrutiny from agencies such as the National Clinical Assessment Authority (NCAA), Primary Care Organisations, and their own regulatory body through measures such as CPD and revalidation. In addition, dentists also need to be aware that the General Dental Council is proposing to introduce a new private complaints procedure, while the Department of Health has recently introduced reforms to the independent review stage of the NHS complaints procedure.

As a caring profession, the vast majority of dentists want to ensure they provide the best care and treatment to patients. At the same time, it's important that dentists can rely on their dental defence organisation to support them with ethical and legal advice, and help with a complaint or a clinical negligence claim. One of the most important debates for today's dentists is what represents the best protection for dentists in the event of a claim: traditional discretionary indemnity or clinical negligence insurance. Rupert Hoppenbrouwers, Head of the DDU, the specialist dental division of the MDU, argues in favour of insurance, explaining that 'nearly all UK dentists are members of a defence organisation, but the majority have no right to receive assistance in the event of a claim'.

In other articles, Iain Cuthbertson, a dento-legal adviser at the DDU, looks at the increasing regulation of the dental profession and scrutiny of professional standards (page 5) and the impact this is likely to have on dentists. Bryan Harvey, Deputy Head of the DDU, looks at the risk management procedures which dentists can undertake to improve the quality of care to patients and to reduce the potential for problems which might lead to complaints and claims (page 8).

Whether you have been a member of the dental profession for years or are just starting out, this handy guide to the dento-legal issues is designed to help you meet the demands made on you as a dental professional.



In the event of a claim, are you covered?

Rupert Hoppenbrouwers, Head of the DDU

Dental claims are becoming more complex and more expensive each year. While nearly all UK dentists are members of a defence organisation, the majority have no right to receive assistance in the event of a claim.



Around 70% of dentists, who are members of mutual defence organisations (MDOs) offering only discretionary benefits, are not insured and have only discretionary indemnity for clinical negligence. These dentists have no contractual right to assistance. The defence organisation has to decide in each and every case whether to exercise its discretion to assist. If the organisation decides not to assist, the dentist may face financial ruin and the patient could be denied rightful compensation.

This state of affairs could soon change however, as the Department of Health proposes to make it a legal requirement for all practising dentists to have a valid insurance policy before they can be registered with the General Dental Council¹. The consultation, which closed on 30 October 2004, proposes a Section 60 Order to amend the Dentists Act 1984 to allow the General Dental Council to require all dental professionals, on initial registration and on renewal of registration, to provide the GDC with evidence that they have valid indemnity insurance.

The Dental Defence Union (DDU) welcomes the proposal as we have long called for regulation of the clinical indemnity market to protect dentists and patients. In this article, we will explain why we believe insurance is the only approach for dentists and how it differs from traditional discretionary assistance.

In the complex world of professional indemnity, not all protection is equal

Historically, the only indemnity available to UK dentists for clinical negligence claims was the discretionary assistance offered by the MDOs.

Discretionary indemnity means that while dentists have the right to ask for assistance, they do not have a right to receive it. No company providing discretionary indemnity can give a guarantee that they will assist with clinical negligence claims nor make it clear in advance in what circumstances assistance will be withheld. MDOs offering discretionary assistance only cannot specify (for example, in their literature or to new members) under what circumstances they would grant or refuse assistance, as this may amount to offering a contractual right to assistance and could be held to be conducting unregulated insurance – a criminal offence in the UK. They are required to consider each new claim as it arises and are entitled to refuse assistance without explanation.





If an entirely discretionary organisation declines to exercise discretion in favour of a dental professional – and there are examples of this having happened in respect of dental claims in the UK – the dentist risks financial ruin and the patient may go uncompensated. When one considers that the largest award paid by the Medical Defence Union in recent years on behalf of a dentist was £89,250, you can see the merit in requiring dental practitioners to hold a valid insurance policy to protect them and their patients.

Long-term risks

Most discretionary assistance is provided on an incident occurrence basis. This means that the dentist needs to be a member of a defence organisation at the time the incident occurred, but does not need to be a member at the time he seeks assistance with a claim.

Occurrence indemnity is open-ended and exposes the indemnifier to the risk of vast claims arising years after the event, which is one of the reasons why some Lloyd's syndicates nearly failed. For example, a dentist may not always know if he/she has damaged a patient in the course of providing dental treatment. By the time the patient becomes aware of the damage and sues, often some years after treatment, and assuming the discretionary indemnifier provides assistance, any compensation award paid may be significantly higher than it would have been had the payment been made in the same year as the incident. The subscriptions taken during the year of the incident may not be enough to fund future claims and the defence organisation will need to adjust future subscriptions accordingly.

To fund claims on an incident occurrence basis, mutual defence organisations must rely on continuing membership and be able to increase subscriptions to take account of anticipated rises in claims for damages. Sudden and unforeseen changes in the market place and in the law can add significantly to the financing burden. For example, when in 2001 the then Lord Chancellor reduced the discount rate to 2.5%, Dr John Hickey, then Medical Director of the MPS, wrote to its members: "This reduction in the discount rate represents a substantial increased demand on MPS funds and is retrospective in nature, meaning that past subscription rates have been set too low. Therefore subscription rates must inevitably rise again in direct response to this ..."

The benefits of indemnity insurance

Although for many years discretionary indemnity was considered by the profession to be adequate, it has become apparent that discretionary assistance alone cannot provide the defence demanded by many dentists in a consumer-driven, litigation-conscious healthcare environment. Instead, the DDU believes indemnity insurance has emerged as the only alternative, with several compelling advantages.

Protecting patients

Insurance would protect patients from the risk of going uncompensated in the event of something going wrong with their treatment and provide the certainty which is currently lacking for some dental professionals.

On behalf of patients, The Consumers' Association has said: "...the provision of clinical indemnity should be regulated to ensure that not only practitioners are assured that they have cover if something goes wrong, but also that consumers will be able to achieve redress and receive recompense in this event...".

Industry regulation

Insurance is a highly regulated industry, providing a defined degree of protection for policy holders. The Financial Services Authority (FSA) oversees the financial management of insurance companies in order to protect solvency margins and reduce the risk of capital flight. It also sets standards for systems, sales and policy holder communications, claims handling and complaints procedures which are widely recognised in the financial services industry.

A dentist who is refused indemnity under their insurance policy may seek and be given a reason for that decision. He or she then has recourse to the Financial Ombudsman Service and the civil courts for assistance in challenging the decision.

Bringing dentists into accord with other UK professions

Professional indemnity insurance is already a requirement for most UK professions, including solicitors. Other healthcare professionals such as osteopaths and chiropractors are already required to hold professional indemnity insurance. It is surprising that dentists are not already required to be insured, given the current dento-legal climate when the cost of dental negligence claims continues to rise year on year.





Conformity with other territories

Indemnity insurance is a requirement for practising doctors and dentists in most developed countries, in order to protect patients. Following a crisis in litigation in Australia in 2003, after UMP, one of the largest indemnifiers of doctors and dentists, went into provisional liquidation, the Government made it a requirement that doctors and dentists have professional indemnity insurance, on a claims-made basis, through an approved provider. Doctors and dentists are also required to buy a run-off policy so that after the claims-made policy has expired (for example because the insured has retired, is disabled or has died), incidents that have occurred during the term of the policy remain insured.

The Australian Government's reason for making the change was to ensure that doctors and dentists: "will have access to contracts of insurance, which are legally enforceable, rather than the discretionary arrangements that exist now which provide no certainty ... that claims will be met."

Mandatory indemnity insurance

The DDU believes that indemnity for dentists should be mandatory as set out in the DoH consultation paper. In our view, only a regulated insurance contract can provide dentists with the security they need in the current dento-legal climate.

It should be mandatory for providers of clinical negligence indemnity to provide practitioners with a claims-made insurance policy. Minimum terms should be specified which would provide adequate safeguards for practitioners and their patients. This would give them the security of an insurance contract, subject only to the terms of the policy.

It should also be mandatory for practitioners to purchase a run-off policy to ensure that they and their estates are covered on retirement, disability or death, up to the maximum terms of the policy. In combination with the claims-made policy above, this would provide security for practitioners and for their patients that is as close to insured incident occurrence as is possible, but with a greater degree of financial security than relying upon discretion alone.

If the GDC gets powers under the Section 60 Order as the DoH proposes, the GDC may choose to instigate disciplinary proceedings against any dentist who **practises without indemnity insurance**. Provision will need to be made for the very few patients who are treated and damaged by practitioners who 'slip through the net' by not being indemnified. This should be possible if a fund was established to provide for such eventualities, along the lines that apply to motor accidents.

The MDU has found that many dentists who are members of mutual defence organisations offering discretionary benefits only are quite unaware that they are only entitled to discretionary assistance, and that they have no entitlement to receive the help they require.

These dentists may be unwittingly exposing themselves and their patients to uncertainty in the event of a claim for clinical negligence – and the risk of potential personal financial ruin.

You would not insure your car on a discretionary basis, nor would the government allow you to find out only after a crash whether your indemnifier would pay up. Surely it is equally, if not more important that all dentists and their patients know, rather than hope, that compensation for proven clinical negligence will be available.



Dentists under scrutiny

Iain Cuthbertson, dento-legal adviser at the DDU

Dental professionals are subject to more regulation and greater scrutiny than ever before - from patient and consumer organisations, government, and increasingly from the media. In this article, we examine how this affects dental professionals.

Today's dental professionals practise within an increasingly regulated environment. Not only is their professional body, the General Dental Council (GDC), increasing its powers and scope; there is a plethora of other initiatives designed to ensure that dental professionals conform to minimum standards in a number of areas, from the provision of clinical care to patient safety.

At the same time, a decade of change in the healthcare climate has positioned dentistry alongside other service providers, subject to a high level of expectation and a high risk of complaint if those expectations are not met.

The GDC and Fitness to Practise

No longer are dentists registered for life by their professional body, provided they pay their annual retention fee. The GDC has been developing a new regulatory model which extends its responsibilities to include professionals complementary to dentistry (PCDs) such as dental hygienists, technicians, therapists and nurses, and increases its powers. The changes are being implemented through amendments to existing legislation (Section 60 Order under the Health Act 1999). The first (an amendment to the Dentists Act 1984) was passed in 2001; and the second is currently the subject of a consultation by the Department of Health ('Strengthening the General Dental Council: A paper for consultation') and is due to be laid before Parliament early in 2005.

A central plank of the changes to date has been the introduction of statutory Continuing Professional Development (CPD) and Recertification – lifelong learning that requires all dentists to keep their skills and knowledge up-to-date, which may include clinical audits conducted by fellow professionals. All dentists are now required to undertake 250 hours of CPD over a five-year period as a condition of retention on the Dentists Register. Failure to comply with the requirements may ultimately lead to erasure from the Register.

Alongside CPD, proposed changes to the GDC's fitness to practise procedures, if implemented, will mean a unified procedure for conduct, performance and health for all dental professionals. Currently there are separate conduct and health procedures for dentists, with separate panels for each, while PCDs are disciplined by the Auxiliaries Committee of the GDC.

There will be a move away from the concepts of 'serious professional misconduct (SPM)' or 'seriously impaired health' to a concept of fitness for registration, including the regular revalidation of all dental professionals (mirroring the GMC), to prove, on a regular basis, that they are fit to practise in their chosen specialties. The GDC will be able to investigate a dental professional whose performance appears to fall short of acceptable standards, even when there has been no formal complaint, and recommend remedial action when necessary. Poor performance which falls short of professional misconduct will be referred to the performance review procedure. It is proposed that this procedure will complement existing local and NHS procedures such as practitioner advice and support schemes (PASS), and the National Clinical Assessment Authority (NCAA), to avoid duplication. In effect, a series of less serious complaints, which would not currently amount to SPM, could in the aggregate result in a decision by the fitness to practise panel that the practitioner's registration should be restricted, suspended, or erased.

The GDC also wants to introduce a new range of sanctions, including conditional registration, longer periods of suspension (suspension is currently limited to a maximum of one year) and the power to recommend a minimum period of erasure from the register, judged on a case-by-case basis. In contrast the Department of Health has proposed that erasure should be for a minimum of five years, mirroring the GMC. For dentists, this could effectively mean erasure for life, because after five years away from dentistry it might be difficult to regain all the required knowledge and practical skills.

Finally, the GDC proposes to use powers proposed in the Department of Health's consultation document to introduce a new complaints system for private dental patients to complement the NHS complaints procedure (see below). This would be separate from its existing fitness to practise procedures and open to patients wishing to complain about any aspect of non-NHS dental care, treatment or service involving any member of a dental team. The GDC says that the process would be 'non-confrontational and non-legalistic' though it argues that all registrants have a professional obligation to participate constructively in complaints handling. The proposed process would include an information service to explain the various options available to complainants; and a complaints resolution panel which will be able to make recommendations, including that the dentist should offer an apology or, in exceptional circumstances, that the complaint should be referred to the Director of the Complaints Scheme for further investigation.

New super-regulator

Alongside the GDC, the last few years has heralded the emergence of a new regulatory body whose powers place an additional check on professional standards and conduct.

The **Council for Healthcare Regulatory Excellence** (CHRE, formerly CRHP) was created under the National Health Service Reform and Health Care Professions Act 2002. This 'super regulator' has the power to refer a fitness to practise decision by the GDC or any other healthcare regulatory body to the High Court where it seems to be desirable for the protection of the public, either because the decision was too lenient, or because CHRE has concerns over a particular decision. If a case is referred, the High Court has the power to substitute its own decision for the one referred to it, or to refer the case back to the regulatory body for a re-hearing. The dentist whose case is being heard will have a right to be represented at the appeal hearing. By September 2004 CHRE had referred regulators' decisions in relation to doctors and nurses, but no doubt it will see fit to refer a GDC decision in due course.

New independent review stage to NHS complaints procedure

The new **NHS Complaints Procedure**, introduced in July 2004 radically overhauls the independent review stage which now falls under the remit of the Healthcare Commission (formerly the Commission for Healthcare Audit and Inspection). The Commission claims the new process will offer a faster, fairer and more independent investigation. There are three stages to the new independent review system; review, investigation and panel hearings.

Patients or carers who are dissatisfied with how a complaint about NHS dental treatment has been handled at practice level can now take their case to the Healthcare Commission, which will review all complaints it receives. It may then decide to investigate the complaint further and, as a result of that investigation a panel hearing may be held. A panel hearing will always take place if the complainant or the person complained about requests it when informed of the result of the investigation. This contrasts with the previous second stage procedure, whereby it was not uncommon for an independent review to be declined by the NHS trust concerned, usually on the basis that it would add nothing to the first stage procedure.

The Commission stresses that it does not want to create an adversarial atmosphere in panel hearings. A friend or advocate (including a dento-legal adviser) may accompany the dentist and that person may ask questions of the investigation panel or assist the dentist to answer questions and clarify matters. However a representative may not act as a lawyer and may not question witnesses or experts. The panel will seek an explanation and acknowledgement of what went wrong. And at the end of the process it may make recommendations about how to improve services. It cannot award compensation or offer legal advice. Patients who are dissatisfied with the Commission's verdict can in turn take their case to the Health Service Commissioner (Ombudsman).

The NCAA

The **National Clinical Assessment Authority** (NCAA) has the power to investigate the performance and competence of NHS dentists and is likely to attain growing significance for the profession. Primary Care Organisations (PCOs) and other NHS employers with a concern about a particular NHS dentist can refer him or her to the NCAA for performance review, putting dentists under even greater scrutiny. Previously, there was no formal mechanism for dealing with alleged underperformance – some cases were handled informally by the PCO, others were referred to local PASS procedures, while some were referred for formal disciplinary action by either the PCO or the GDC. If concerns remain following an NCAA assessment, it can then refer the dentist to the GDC for investigation. The primary intention of all the various performance procedures is to substitute remedial action for disciplinary action, with the aim of the dentist continuing to practise, or returning to work as quickly as possible, rather similar to the current GDC health procedures. This is to be welcomed, but it remains to be seen how the NCAA and GDC procedures will work in practice.

In July 2004, the Department of Health announced plans to make the NCAA a separate division of the **National Patient Safety Agency** (NPSA) as part of a reorganisation of so-called 'arms-length bodies'. The NPSA is currently responsible for maintaining an anonymous system for frontline NHS staff to report patient safety incidents. However, the DoH is keen to stress that absolute confidentiality will be maintained between the functions so that anonymous reporting within the main NPSA is unhindered.

Increase in negligence claims

In addition to increased scrutiny by the GDC and regulatory bodies, the MDU has seen an upward trend in both the incidence of negligence claims brought and settled against dental members and the average settlement amount. In 2003, the combined cost and frequency of claims increased by 12.5%, well above the rate of inflation.

One reason is that Lord Woolf's overhaul of the system in 1999 has made access to civil justice faster and easier – in particular the introduction of conditional fee arrangements has made litigation more accessible for those aggrieved patients who might otherwise have had to fund their own legal costs for investigating a potential claim.

Another aspect of dental litigation has been the emergence of firms of solicitors specialising in dental claims, as well as specialist dental claims departments within existing firms.

The changing dento-legal scene

There is no evidence to show that standards of dental care are slipping: set against the millions of consultations which happen in the UK each year, the numbers of complaints and claims are still relatively few.

However, dental professionals are facing increased scrutiny from their professional body and regulatory agencies such as CHRE and the Healthcare Commission, while a dentist can now expect to receive a complaint or a claim at least once during their career.

The final article in this supplement explains how dental professionals can improve their risk management, with the aim of raising the standard of dental care and preventing complaints and claims.





Risky business?

Bryan Harvey, Deputy Head of the DDU

No dentist wants to take risks with patient care and a failure in any aspect of service – clinical or administrative – can also expose dentists to the threat of complaints, disciplinary action, or claims for negligence. Risk management is an essential element of good practice management.



Your patient is sitting comfortably in the chair, mouth open, waiting for you to fit a crown. Accidentally, you drop the crown in the patient's mouth, he swallows and it disappears down his throat without his knowing. Do you:

- say nothing and hope for the best?
- finish the treatment then tell the patient what's happened, reassuring him that he will suffer no ill-effects?
- immediately sit the patient up, explain what's happened, call a taxi to take him to A&E accompanied by a member of staff for a chest and abdominal X-ray and follow up with a phone call later in the day to make sure he is alright?

In real life, option c proved the right course of action. No harm was done to the patient as the crown showed up in his stomach and the follow-up call re-established goodwill between dentist and patient. No complaint or litigation followed, but how different the outcome could have been if the dentist had not taken adequate steps to ensure an accidental slip of the hand didn't escalate into damage to the patient and a formal complaint or claim for clinical negligence.

We are a caring profession and practise in a service-driven environment. It makes sense for dental professionals to strive to manage risk, to improve the quality of care to patients and to reduce the potential for problems which might lead to complaints and claims.

What is risk management?

Under NHS GDS clinical governance requirements, dental practices should have a quality assurance system to ensure all dental care is of consistent quality. Risk management forms an important and integral part of the quality assurance system.

Risk management is the systematic analysis of potential areas of risk, and the implementation of simple measures to eliminate or control those risks. It requires common sense and an insight into what patients experience when they communicate with or attend your surgery. The DDU advises that the entire practice team is engaged in the process.

In the DDU's experience, the areas of practice that commonly give rise to complaints and claims are:

- Communication – around one third of complaints are due to a failure of communication, including allegations of rudeness.
- Administrative and processing errors.
- Failures in routine ongoing patient care – eg overlooking a symptom that eventually leads to tooth loss.
- Clinical management

A mismatch between patient expectation and the service provided can be a recipe for dissatisfaction, whether this concerns complex aesthetic treatment or the way the phone is answered. Your risk analysis should look at all areas of your practice, assessing the potential frequency and severity of each risk. Clearly, you will wish to address risks that happen most often and have the greatest effect immediately, to eliminate or reduce harm to patients and disruption to the smooth running of the practice.

Where do I start?

The DDU suggests a good starting point is to look at your practice through your patients' eyes. Advertising, for example, is the first impression prospective patients will have of you. Does it represent exactly what you want to say and have you followed the GDC's guidelines set out in *Maintaining Standards* (Section 7) on the use of adverts?

An effective appointments system is essential. Make sure patients are kept informed if the dentist is running late and apologise promptly for delays or cancellations. This can be done easily and yet it can have a very positive effect on how the practice is perceived.

Take a good look at your reception area. Would you find it friendly and welcoming? Are your staff unfailingly cheerful? Do you phone up your own practice anonymously to assess the greeting? Customer relations training for reception staff is valuable if your risk assessment reveals recurring complaints. Reception desks are also an area where confidentiality can be compromised – set strict rules about what can and cannot be discussed by staff in the reception area and ensure that computer screens containing patient information cannot be seen by anyone other than the dental team.

Unclear procedures for patients wishing to make emergency and out of hours appointments can be a cause of grievance. Patients need clear information about what to do, under what circumstances. Make clear in your practice booklet what you regard as an emergency. You could phone up and test your own system from time to time to make sure it works.

Can you honestly say that your communications are up to scratch? Make sure straightforward points are clear to patients – for example, that missed appointments are billable.

Risk management in practice

Poor communication in the course of clinical treatment is potentially very serious, especially when it involves inaccurate record keeping, failing to obtain consent or breaching patient confidentiality. DDU data shows these to be major factors in complaints, claims and disciplinary investigations.

On the record

The most basic of clinical tools, patient records can help in communication between dentists and colleagues, dentists and other healthcare professionals, and are an essential aide memoire to ensure that a patient receives appropriate clinical care. Records also support audit and can provide crucial evidence should a complaint or claim arise. It is essential to make a complete and contemporaneous record every time you see or treat a patient.



Records must be legible and up-to-date and include an accurate medical history. Radiographs should be of good diagnostic value, correctly labelled, and preferably mounted.

Hand-written notes must be legible and intelligible to other people, and contain sufficient detail for the dental professional and others to know precisely what treatment has or will be given, by whom and when. For example, when a hard tissue charting is recorded, showing treatment is required, then this will need to be annotated later to show when the treatment has been provided. This may help prevent omissions in treatment.

Errors need to be scored through with a single line, so that the original can still be read, and the correct information can be written alongside, signed, and dated. If a record card is damaged, for instance with a spilt drink and is rewritten, the original should not be thrown away and the new card should indicate it has been rewritten, why and when.

Reading records carefully is just as important as keeping them, as this example illustrates: a new associate in a practice removed what he thought were the patient's upper first premolars, following instructions in a letter from the orthodontist. Only afterwards did he read the patient's notes fully and find that the upper first premolars had already been extracted – he had removed the upper second premolars erupting in their place.

A matter of consent

A patient who sits in the chair and opens his mouth may be assumed to be consenting to an examination. But is he or she consenting to any other treatment, even if it has been discussed beforehand? The DDU strongly recommends that every practice has a policy on obtaining consent.

Competent adults (over 18 years), children aged 16 and 17, and children under sixteen who are 'Gillick competent' – that is, who understand the nature, purpose and potential hazards of treatment - have a right to give or withhold consent to examination, investigation or treatment. Consent is only valid if the patient is fully informed about what the planned treatment involves and knows and understands the potential risks. He or she must also be competent to make an informed decision and make it free from duress.

Before beginning any treatment, you should also ensure the patient understands fully what will be carried out and why, and the consequences of not having treatment. You should also explain any fees and payment options in advance of starting treatment. You are advised to provide a written treatment plan and fee estimate, and this is mandatory if the treatment is to be extensive or expensive (paragraph 3.6 of the GDC's 'Maintaining Standards'). Patients should be clear whether treatment is provided under NHS or private arrangements, or a mixture of the two.

For adult patients who are not competent, treatment can be carried out without consent if it is in the patient's best interests. Take care to ensure treatment is in the patient's best interests, and seek the views of carers or relatives to support your proposed treatment plan.

In confidence

The majority of dental practices are scrupulous in protecting patients' privacy. However, breach of confidentiality is a surprisingly common cause for complaint, and it often happens inadvertently – a conversation overheard at the reception desk, for example.

Confidentiality applies to all patients, including children, who may sometimes not wish their records to be disclosed, even to their parents. It also applies if a school calls to seek confirmation that a child has attended a dental appointment.

It is particularly important that all staff understand the requirement for confidentiality, both in and outside the surgery. One DDU case involved a patient who told her dentist that she was pregnant. Several days later, the practice nurse saw the patient's mother in the supermarket and congratulated her on the news. The mother had no idea her daughter was pregnant. Very upset at this breach of confidentiality, the patient complained to the GDC. One result of this case was that all practice staff received further training in confidentiality and the practice introduced an induction programme for new employees.

Certain circumstances allow for a patient's records to be released, for example, under a court order. However, it is always advisable to ask for the patient's written consent before disclosing any information. If in doubt, contact your dental defence organisation for advice.

Identifying and reducing risk

Identifying and reducing the risks inherent in modern dental practice is not rocket-science. The key is to be aware of where the risks might lie in your surgery. Spot the areas of weakness, take action to close the gaps in your procedures effectively and you are likely to find your patients are satisfied and the practice is less vulnerable to complaints or claims – leaving you to focus on patient care.

The DDU publications *Risk Management in Dentistry (Modules 1 and 2)* provide step-by-step guidance on the risk assessment process.

The cases mentioned are fictitious, but based on cases from the DDU's files. Dentists with specific concerns are advised to contact their dental defence organisation for dento-legal and risk management advice.



Rest assured You're with the DDU

You work in a world where negligence claims are becoming increasingly common. You're meticulously careful, and you never expect accidents to happen – but they do, on average at least once in every dentist's career. If you're not properly indemnified, a claim for clinical negligence could spell financial ruin.

But when you're with the Dental Defence Union you can relax. As the specialist dental division of the MDU – the leading defence organisation for UK healthcare professionals – the DDU offers unequivocal dento-legal advice, unsurpassed support and unrivalled insurance cover.*

Call our free membership helpline now to find out more on **0800 085 0614**

MDU Services Limited 230 Blackfriars Road London, SE1 8PJ

