SADA Professional Advisory Bulletin

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Please check the above details are correct.

Dear SADA Member

CLINICAL

We have every confidence that our esteemed members relished what can only be described as an exceptionally successful SADA Dental Congress, possibly the most triumphant to date. The event unfolded over a weekend brimming with valuable networking and profound learning experiences and we trust that the information gained over the Congress will serve members for a long time to come.

Please refer to the latest industry updates:

Recommendation by the CMS for 2024 contribution increases

Using the CPI as a proxy metric for the industry's affordability of yearly contribution increases, the CMS has recommended that medical schemes restrict their cost estimations for tariff increases to 5% plus appropriate utilisation forecasts for the 2024 benefit year. This is in line with the CPI forecast by the South African Reserve Bank and is envisioned to safeguard participants of the medical scheme from greater financial hardship and the possibility of losing health insurance coverage owing to affordability limitations.

Furthermore, the CMS has indicated that contribution increases more than the CPI plus a reasonably estimated utilisation factor will be reviewed and allowed based on the strength of the provided motivation that must include a comprehensive actuarial business plan that justifies said increase. Medical schemes may only implement contribution increases that have been approved by the Registrar.

CPD Backlog

The HPCSA has advised that they are currently experiencing a backlog in processing CPD information submitted by SADA and other service providers due to the influx of submissions received as a result of the notifications sent by the HPCSA to all practitioners who are non-compliant. The Council has requested that practitioners remain patient as the backlog is cleared and apologize for any inconvenience caused.

Dental Assistant Examinations

Despite previous communications sent to members in this regard, SADA Head Office has received a number of queries in respect of the upcoming Dental Assistant examinations in November 2023 and March 2024. Members are reminded **that only dental assistants who were previously registered under the Grandfather Clause** (even if this registration has since lapsed) are eligible to register for and write the examination. Dental assistants who failed to register under any of the implemented Grandfather Clauses are unfortunately NOT eligible since registration under the Clause has closed years ago.

Coding Updates

Various codes have been updated in the latest edition of the SADA Dental and Oral Codes September 2023. Members are advised that a list of these amendments is available on the SADA Website at and the most recent version of the guideline is available for free download by SADA members by following the steps below:

1. Log in to www.sada.co.za with your username and password
2. Click on ‘’Publications and Press”
3. Click on ‘The SADA Dental Codes and Guidelines’
4. Choose the Excel format for your download and save it for future reference. The PDF format will be uploaded to the website in the near future.

Cost-neutral coding acceptance

To date, Momentum and CAMAF have informed SADA of their acceptance of cost neutral codes for payment as of 1 October 2023. SADA remains in negotiation with other major schemes. For a list of the newly accepted codes, click here New_SADA_tariff_codes_accepted_by_MHS.pdf (momentum.co.za)

Use of tooth whitening products by beauty therapists

The Board for Dental Assisting, Dental Therapy and Oral Hygiene has advised all its stakeholders that SAHPRA has provided clarity regarding tooth whitening products being classified as non-medicinal, which means that it is open to use by beauticians. The Board has repeatedly highlighted the dangers of allowing non oral health professionals to administer these products to the public and will continue to raise objections with SAHPRA.

Biannual GEMS / Denis meeting

In the second biannual meeting held between GEMS/Denis and SADA, the scheme advised the Association of the following concerns regarding coding and claims:

1. There is a gross underutilization of fissure sealants **(code 8163)** by dentists. A total of only 4% of dentists on the GEMS network claimed for fissure sealants in 2022, while in 2023 to date, only 3.5%. Members are encouraged to place fissure sealants *when clinically indicated* since they serve a preventative function and can therefore protect against caries formation in the future. GEMS further advises that in network providers, claims for fissure sealants emanate from the Risk benefit for patients equal to or under the age of 14 years on the Tanzanite and Beryl plans and equal to or under the age of 18 years for patients on the Emerald, Everald Value and Onyx options.
2. **Code 8104 (limited oral examination)** is routinely being claimed with each follow up appointment such as those for dentures, root canal treatments etc. Members are advised that 8104 may only be claimed as a consultation for a specific problem not requiring a full mouth examination and treatment planning, and may be claimed when all treatment from code 8101 has been completed **OR** for a

specific problem which does not form part of the original treatment plan. It should not be claimed for a regular appointment.

3. **Code 8101 (oral examination)** must always be accompanied by a complete dental charting and treatment plan.
4. When claiming for a periodontal examination **(code 8176)**, members must take note that this code includes, at the very least, a periodontal charting together with a plaque index and bleeding index.
5. There seems to be a confusion when claiming for code **8166 (application of desensitising resin or caries arresting agent)** vs **8167 (application of desensitising medicament).** Members are reminded that an adhesive resin on the cervical tooth surface would be coded as 8166 as well as the use of Silver Diamine Fluoride, whereas 8167 may be used to code for the application of topical fluoride to treat persistent pain (i.e., not to prevent decay) on teeth and/or root surfaces.
6. **Code 8121 (diagnostic photograph/image)** should only be billed when taken for clinical or diagnostic reasons. Those taken for patient education may not be charged for.
7. The application of **code 8108 (Intraoral radiographs/images - complete series)** must be correctly understood before it is to be claimed. A complete series is made up of at least eight intraoral radiographs (periapicals and/or bitewings). A complete series for diagnostic purposes is generally required once per treatment plan only and a second set may be required in exceptional circumstances e.g., following periodontal surgery.

LEGAL

Bad mouthing – Professional reputation of colleagues

There is a trend emerging where practitioners are commenting about the dental work carried out by their colleagues and expressing opinions about the dental work without first liaising with their colleagues. Worse still is that they are expressing opinions about the previous dentist's work to the patient sometimes as 'less than perfect work'.

With disappointing regularity, practitioners are faced with their patients who are informed by their subsequent dentist who has seen fit to make inappropriate remarks of a disparaging nature about their colleagues' treatment.

Sometimes criticisms are made by clinicians who feel that they have a duty to offer their views on treatment provided elsewhere, whenever a patient seeks their professional opinion and advice.

There is also a small minority of clinicians who appear to see themselves as self-appointed arbiters of what does and does not constitute an acceptable standard of care. They are quick to criticize, and they invariably recommend extensive 'remedial' dentistry -- often at considerable cost. These same practitioners, however, seem unable to accept any criticism of their own work or challenge of their opinions.

Such an opinion may be given with the best of intentions, but without knowing all the relevant facts (including what problems were faced by the previous practitioner at the time); such criticisms can only be regarded as uninformed and possibly even irresponsible. As a result, they will usually be judgmental rather than objective and factual.

Practitioners' express opinions on treatment for various reasons, for example, not losing out on the patient's business, the possibility of carrying out multiple procedures, the previous dentist being a major competitor, personal bias, professional jealousy or rivalry, wounded pride or business or financial dispute etc.

Understandably, the practitioner referred to will regard such overt (and perhaps gratuitous) criticism as being unnecessary, unethical, and perhaps even defamatory whether or not there might be any justification for their criticisms.

The Ethical Rules of Conduct in Rule 12 specifically provides that “a practitioner shall not cast reflections on the probity, professional reputation or skill of another person registered under the Act or any other Health Act”.

Despite the above ethical rule, practitioners continue to pass comments about their colleagues’ treatment to their patients and even other colleagues.

So, what should practitioners do?

Patients consulted by dentists have a great chance they have had dental work done in the past, which means a practitioner may need to contend with a range of techniques and degrees of professionalism. So what should dentists do if a patient complains about ‘shoddy’ dental work or it is clear that previous work is not up to scratch?

Practitioners must remember patients often also have a very poor understanding of what is been happening in their mouth and of their previous treatments, so when a patient provides information on when treatment was done or that it was substandard it is always advisable to be a bit cautious about taking that as the truth.

Practitioners also cannot reliably rely on the information provided by the patient without testing its veracity. There may be other reasons that the patient is bad-mouthing the previous dentist for example, outstanding accounts not settled, abusive behaviour, benefits exhausted, appointments not kept, patients attending a wedding and wanting a quick fix but do not come back for months or years, walk around with temporary fixes or chose less than the ideal situation which subsequently failed, etc.

The simple answer is that dentists should avoid discussing the standard of work of other dentists with patients. If a patient seeks advice from a dentist who is not their usual practitioner about their oral condition, the dentist should endeavour not to say anything which calls into question the integrity of their usual dentist. If the practitioner encounters something that is not correct, they need to say this professionally and objectively after speaking to their colleagues to get to a full picture. Importantly, this must be done objectively and without apportioning blame.

Even if an opinion is given with the best of intentions, but without knowing all the relevant facts (including what problems were faced by the previous practitioner at the time); such criticisms can only be regarded as uninformed and possibly even irresponsible. As a result, they will usually be judgmental rather than objective and factual.

It is important to understand that good relationships with colleagues and other practitioners strengthen the bond between dentist and patient and enhance patient care. Specifically, it states that good practice involves acknowledging and respecting the contribution of all practitioners involved in the care of the patient and always behaving professionally and courteously to colleagues and other practitioners.

Practitioners are also required to act at all times in a manner that upholds and enhances the integrity, dignity, and reputation of the profession.

Patients are entitled to know about their dental and oral health, and practitioners have an ethical duty to inform them on an honest and factual basis. If this can be done without denigrating one's colleagues based on hearsay, both patients and practitioners can benefit.

Problems are more likely to arise when comments extend beyond objective clinical opinions and become critically judgmental of a professional colleague. When these comments are fuelled by personal animosity between the two dentists, with the second dentist perhaps deliberately embellishing and exaggerating the situation, this raises ethical questions about the second dentist over and above any clinical issues surrounding the dentist whose work is under scrutiny.

It is important to bear in mind that things are not always as they appear (or as first related by our patients) and there are two sides to most (if not all) stories.

When reviewing the work of another practitioner, a prudent approach is to describe things in the same way that you would wish to be spoken of yourself, were the roles to be reversed. There is nothing new in dentistry -- as in life in general -- with regard to the perils of criticizing others.

Risks to patients

If, during your professional life, you see or hear something that leads you to believe that patients could be placed at risk or the quality of their care compromised by the actions or performance of a professional colleague, then you have an ethical duty to take reasonable and appropriate steps to:

• Raise your concerns with the colleague directly if this is appropriate to the situation
• Deal with the problem yourself (if this is within your power)
• Take advice as to how best to manage the situation.

It is also worth remembering that you may be helping a professional colleague to come to terms with, or to deal with, a problem that previously they might not even have acknowledged. Dealing with a problem at a lower level, however awkward at the time, can prevent it from escalating into a situation where the stakes (and the professional consequences) are higher.

If there is conflict between practitioners on the treatment of patients, every effort should be made to contain them in a manner which

• avoids placing patients at risk.
• maintains the continuity of patient care and safeguards their rights and the quality of the dental care they receive.
• avoids bringing the profession into disrepute.
• maintains public confidence in the profession.
• treat professional colleagues as they would wish to be treated.

Every effort should be made to manage any differences of professional opinion through appropriate channels and in an ethical and professional manner.

Conclusion

The dental healthcare profession is a noble profession. Dentists have a duty to uphold its reputation. The reputation of the profession is important for the public's trust in the profession. Without trust, clinical practice is compromised, and the best interests of the patient fall by the wayside.

A negative comment about a colleague said to a patient, can create a negative perception of the profession. Before making a comment about a colleague, ask yourself if it will benefit the patient in any way. If not, don't say it.

"A good reputation is more valuable than money" Publilius Syrus (1st Century)

First Aid, First Aid Boxes, and Equipment in a Dental Practice

The law requires dentists as employers to take reasonable and practical steps to provide and maintain a safe and healthy work environment.

The provision of first aid is an important element in ensuring the health and safety of persons in the practice.

First aid is emergency care provided for injury or sudden illness before emergency medical treatment is available. First aid helps to preserve the lives of employees and allows them to receive immediate medical attention.

In South Africa, this is addressed by prescriptions of the General Safety Regulation (GSR) 3 of the Occupational Health and Safety Act (Act 85 of 1993, as amended).

When should first aid be provided at the workplace?

The Regulation stipulates that ‘‘an employer shall take all reasonable steps that are necessary under the circumstances, to ensure that persons at work *receive prompt first aid treatment* in case of injury or emergency’’.

When is a first aider required?

In the case of dental practices, one first aider must be appointed for *every 50 employees*.

Qualifications of the first aider

The first aider should be in possession of a valid first-aid certificate, issued by a person or organization approved by the Chief Inspector’s Office for this purpose.

Where hazardous chemical agents or hazardous biological agents are used, handled, processed, or manufactured, the first aid worker should be trained in the first aid procedures that are necessary for the treatment of injuries that may result from such activities.

In the case of injuries or wounds

The employee’s duty: An employee suffering from an open wound, cut, sore or any similar injury, who works where hazardous chemical substances or hazardous biological agents are used, handled, processed or manufactured, shall report such injury to his employer as soon as possible.

The practitioner’s duty: The practitioner may not permit such a person to continue working before the injury has been cleaned with soap and water or with a diluted disinfectant and has been suitably dressed to eliminate blood or bodily fluid seepage through the dressing, where necessary.

When should first aid boxes be provided?

A first aid box must be provided where more than five employees are employed at a workplace.

How many first aid boxes should be provided?

The number of boxes required must be determined by the practitioners' risk assessment, which should take into account the type of injuries that are likely to occur at a practice, the nature of activities performed, and the number of employees.

Placement of first aid boxes

The practitioner is to provide a first aid box or boxes which is *available and accessible for the treatment* of injured persons at that practice. The placement will, thus, be based on the practitioner’s risk assessment.

Contents of the first aid box

Only suitable first aid equipment, as listed in the prescribed Annexure of the General Safety Regulations, must be provided.

Minimum contents of a First Aid Box

In the case of shops and offices, the quantities stated under items 1, 8, 9, 10, 14, 15, 17 and 18 may be reduced by half.

Item 1 Wound cleaner / antiseptic (100ml)
Item 2 Swabs for cleaning wounds
Item 3 Cotton wool for padding (100g)
Item 4 Sterile gauze (minimum quantity 10)
Item 5 1 Pair of forceps (for splinters)
Item 6 1 Pair of scissors (minimum size: 100mm)
Item 7 1 Set of safety pins
Item 8 4 Triangular bandages
Item 9 4 Roller bandages (75mm x 5m)
Item 10 4 Roller bandages (100mm x 5m)
Item 11 1 Roll of elastic adhesive (25mm x 3m)
Item 12 1 Non-allergenic adhesive strip (25mm x 3m)
Item 13 1 Packet of adhesive dressing strips (minimum quantity of 10, assorted sizes)
Item 14 4 First aid dressings (75mm x 100mm)
Item 15 4 First aid dressings (150mm x 200mm)
Item 16 2 Straight splints
Item 17 2 Pairs large and 2 pairs medium disposable latex gloves
Item 18 2 CPR mouth pieces or similar devices

A spillage kit

On 28 October 2005, the Department of Labour published the “Draft General Health and Safety Regulations” (Government Gazette, No. 28162). Regulation 7 of these Draft Regulations provides proposed changes to first aid, emergency equipment and procedures.

The Draft Regulations aimed to add additional items to the current prescribed content of the first aid box. The content of the so-called “spillage kit” would include the following items:

Item 19 An adequate supply of absorbent material for the absorption of blood and other body fluids spilled.
Item 20 Disinfectant to disinfect the area after cleaning up blood and other body fluids spilled.
Item 21 2 Pairs large and 2 pairs medium disposable rubber household gloves
Item 22 A suitably sized impervious bag for the safe disposal of blood and other body fluid contaminated biohazardous materials.

The proposed changes of the Draft Regulations did not come into effect. It would, however, be good practice to add the abovementioned items to the first aid kit. Some providers of first aid boxes refer to this as Regulation 7 first aid boxes.

May practitioners keep any other articles or substances, such as headache tablets, cough mixtures, or any other oral medicine, in the first aid box?

There is an ongoing debate about stocking certain medicines, like headache tablets, cough mixtures, or any other oral medicine, etc. in the first aid box and dispensing these to employees.
These items are not listed in the prescribed Annexure.

Signage for first aid boxes

The practitionershall post a prominent notice or sign in a conspicuous place at a workplace, indicating where the first aid box or boxes are kept as well as the name of the person in charge of such first aid box or

boxes.

The use of inspections and inspection lists

Articles used for first aid purposes should be replaced as soon as possible. To ensure that this is done, employers should perform regular inspections of their first aid boxes.

Regular inspections of first aid boxes and equipment will ensure that equipment stays in good working order and that first aid boxes always contain the prescribed ‘‘minimum contents’’. Items contained in the box should also be inspected for expiry dates; expired items must be discarded and replaced immediately. These types of inspections are called continuous risk assessments. Formal checklists could be a useful tool to ensure compliance with the prescriptions of the relevant regulations.

Yours in oral health

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14 Oct	**SADA YDC - KwaZulu-Natal Branch - 14 October 2023 (KZN059)**
21 Oct	**SADA Southern Cape CPD Day - Fancourt 21 October 2023 (WC057)**
17 Nov	**SADA Gauteng South Branch Mini Congress (GS067)**
30 Aug	**2024 SADA Dental & Oral Health Congress and Exhibition**