SADA
ADVISORY
The South African Dental Association Newsletter
Informing Oral Healthcare Professionals
Bulletin

SADA Professional Advisory Bulletin

- Ethical Bulletin - Handling Complaints – Part 4
- HPCSA Business Practices Policy

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Dear SADA Member

This is the fourth of the four-part series that focuses on improving our member's understanding of patient complaints. SADA introduced an independent complaint resolution service in 2012 as an alternative to the HPCSA for patients wanting to complain about their dental care. Since then, the service has successfully resolved over 5 500 disputes between patients and dentists. We want to share valuable experience gained over the last 12 years with our members to help them prevent patient complaints.

CLINICAL

Ethical Bulletin – Handling Complaints – Part 4

In the previous three editions, we provided an overview of handling complaints from patients in a dental practice and emphasised the importance of a Practice Complaints Procedure. In this final edition, we will discuss some useful communication skills and demonstrate how our behaviour can increase the risk of a patient complaint.

It is often difficult to understand why some competent and experienced dentists and specialists receive more complaints from patients than their colleagues. Many studies worldwide compare the behaviour of doctors with a high risk of litigation to those with a low risk of litigation.

Doctors with a low risk of litigation

- They seem to spend slightly more time with their patients at each visit.
- Know their patients better, for example, their jobs, hobbies and the names of their children.
- They have good communication and listening skill.
- They respect their patient's dignity, privacy and their time.
- They are polite but not overfamiliar.

Whilst doctors with a high risk of litigation

- Patients perceive the interaction as rushes during appointments. For example, the dentist keeps looking at his watch or asks the assistant about the next patient while the patient is still in the chair.
- They have poor listening and communication skills.
- Do not know their patients; patients feel like ‘’just a number’’.
- They fail to establish their patient's expectations.

- Patients experience rudeness and ignorance (Haynes, 2007).

We cannot change our character as individuals, but we can significantly reduce our risk of a patient complaint by consciously changing our behaviour.

Essential communication skills that we should be aware of and develop are our nonverbal, verbal, and listening skills.

Non-verbal skills
Studies have demonstrated that up to 70% of our patient communication is nonverbal. Our "body language" helps to reinforce or contradict verbal comments and tends to override our verbal communication if contradictory (Silverman and Kinnersley, 2010). Being mindful of our body posture, eye contact, and facial expressions is important.

Healthcare providers can use several strategies to consciously improve non-verbal communication.

For example:

- Smile and maintain appropriate eye contact without staring.
- Show genuine interest in what the patient is saying. Avoid tapping your fingers, gazing out the window, checking the clock, yawning, or any other actions that might suggest boredom or impatience.
- Sit whenever possible and lean forward to demonstrate engagement. Avoid standing over the patient in a paternalistic manner.
- Nod your head to indicate active listening.
- Keep an open and relaxed posture, avoiding crossed arms or other gestures that might imply reluctance to listen, disapproval, or judgment. Encourage the patient to share all relevant information.

Verbal skills
This involves not only the words you use but also the way in which you use those words and your tone of voice. When dealing with complaints on the telephone, these skills become essential as your voice and tone contributes a great deal to the patient's perception of you and your manner. What do you sound like?

Listening skills
Healthcare practitioners may interrupt patients very early during consultations (Langewitz et al. 2002, Rhodes et al. 2004). Failure to listen may lead to the perception that the consultation was 'rushed' or you are not interested. Active listening involves eye contact, not interrupting, nodding and recounting the patient's story and their emotion back to them.

Effective communication in healthcare is essential for patient health and safety, and it offers several key benefits:

- **Understanding Patient Needs:** Comprehending patients' perspectives, including their emotional states and individual requirements, is crucial for providing appropriate care.
- **Tracking and Communicating Changes:** Clear, accurate communication is necessary to convey frequent changes in medications, procedures, and administration, ensuring timely and proper patient care.
- **Creating Synergy Among Healthcare Teams:** Flawless communication among healthcare professionals aligns staff members, reduces patient stress, and increases efficiency.

Other benefits include:

- **Making Personal Connections:** Building trust and compassion with patients and colleagues humanizes healthcare providers and helps patients relax.
- **Cultural Awareness:** Open communication fosters understanding of diverse backgrounds, preventing awkward interactions.
- **Better Patient Satisfaction:** Effective communication enhances patient satisfaction, decreases complaints, and reduces readmissions.

In summary

- Complaints are a reality for anyone providing professional services. Even experienced dentists and specialists receive complaints.
- Complaints can easily be experienced as an insult or perceived as a threat. However, they should rather be seen as an opportunity to resolve the complaint without the involvement of third parties, and a chance to improve our practice and ourselves.
- The majority of complaints can easily be resolved through a Practice Complaints procedure.
- We can change our behaviour to lower our risk of being patient complaint.

LEGAL

HPCSA BUSINESS PRACTICES POLICY

The Health Professions Council of South Africa (HPCSA) published and distributed the above policy on 24 April 2024. This was a result of changing socio-economic environment in South Africa and its impact on the provision of healthcare in the country, the HPCSA felt the need to determine what may be regarded as acceptable business practices in the healthcare sector in order to guide health practitioners and to protect the public.

The policy sets out amongst others acceptable business structures that dentists may practice under, corporate involvement in practices, employment or appointment of practitioners, franchise, managed care models, clinical advisors, sharing of fees etc.

A number of definitions are introduced and described. Failure of practitioners to comply with the policy may constitute an act or omission in respect of which the professional board concerned may take disciplinary action in terms of Chapter IV of the Act, following an inquiry. All health practitioners are required to comply with this policy.

Acceptable Business Structures

The business structures are generally accepted by the HPCSA are:
i) Solo Practice
ii) Partnerships/Groups/Organisations
iii) Associations
iv) Personal liability companies (incorporated practices – Inc.)
v) Franchises (subject to compliance with the ethical rules).

Practitioners may not embark on any other business formation or structure, such as (Pty) Limited. A dentist is permitted to outsource the administration or establish a company to manage the administration of her/his business, provided that such arrangement is not in violation of the established ethical rules of the Council.

Corporate Involvement

A person (whether a natural person or a juristic person company) who is not registered in terms of the Act does not qualify to, directly or indirectly, in any manner whatsoever, share in the profits or income of such a professional practice.

Practitioners are not permitted to transfer an income stream generated from patient to such a person, give shares in a professional practice, transfer income or profit to a provider by paying a fee which is not market related or paying a service provider with some or other benefit intended to allow the service provider to share, directly or indirectly, in the profits or income of such a professional practice or to have an interest in such a professional practice.

The bottom line is that direct or indirect corporate ownership of a professional practice by a person other than a health practitioner registered in terms of the Act is not permissible.

Any agreement for corporate involvement with dental practice should be negotiated on an arms-length basis in terms of which an objectively determined market-related and fair remuneration is established. Practitioners must avoid potential conflicts of interest and maintain professional autonomy, independence, and commitment to applicable professional and ethical norms. It is unacceptable to compromise your autonomy for an incentive or inducement.

Corporate involvement is permissible under the following conditions:

1. Ethical rules and policies of the Council to be complied with.
2. Health practitioners should take full responsibility for the compliance of the corporate unregistered party with the ethical rules and policies of the Council.
3. Health practitioners should not hide behind the corporate veil but should take individual responsibility for all business transactions and operations of the business.
4. No hiving off of fees to a corporate entity.
5. No coercion by corporate entities on practitioners to enter arrangements that would violate the ethical rules.

Employment of dental practitioners

Dentists may employ fellow registered health practitioners in accordance with the provisions of ethical rules.

If a dentist wants to be employed or appointed by any unregistered entity, agency, agent, institution, or person, such employment or appointment should be aligned with the interests of the profession and the public. Dentists must remember that they are responsible for evaluating whether the prospective contract of employment is suitable for conducive ethical and professional practices in terms of ethical rule 18.

Dentists may use the following criteria as a guide:

Motive or Goal – for employment should not be about primarily extracting financial benefits to the detriment of the public.

Service to specific groups of people- the employment relationship or appointment should strive to serve the needs of citizens, for example, a non-profit, charitable and similar organisations.

Clinical independence of health practitioners - the dentist should be satisfied that the employer will place sufficient measures to mitigate business practices that would compromise patient care or promote the provision of services for the primary purpose of acquiring financial or material benefit. The dentist should also check that the employer

mitigates against undue influence and exertion that may compromise his/her clinical independence.

Method of remuneration – the dentist should ensure that potential ethical transgressions, such as perverse incentive is avoided. Practices that enrich a health practitioner, or a private hospital either financially or in kind at the cost of a payer or patient with no scientific evidence or cost-effective considerations are not acceptable.

Clinical governance – a dentist should ensure that the employer's offer includes sufficient measures of how the professional autonomy of the health practitioner will be maintained to make independent clinical decisions without undue interference.

Peer review mechanisms – dentist should check how the internal peer review mechanisms are structured, constituted, governed and supported by evidence-based practices.

Franchises

A franchise implies the sale of exclusive rights to the franchisee and in general is also dependent on advertising of the franchise.

Dentists engaging in franchise arrangements of healthcare services should guard against practising in any form of business which has inherent requirements that violate ethical rules. These include but are not limited to: Rule 3: Advertising, Rule 4: Professional Stationery, Rule 5: Naming of practice, Rule 6: Itinerant practice, Rule 7: Fees and commissions, Rule 8: Partnership, Rule 8A: Rooms, Rule 18: Professional appointments, Rule 19: Professional secrecy, Rule 21: Performance of professional acts, Rule 22: Exploitation, etc.

Managed care models

Dentists are permitted to participate in managed care models, group practices, preferred provider networks or any other such models with medical schemes as long as it does not result in them violating the Act, ethical rules, and guidelines.

Dentists including those in clinical and non-clinical practice (even as clinical advisors) must at all-times act in the best interest of patients.

Gatekeepers

Sometimes medical schemes appoint a general practitioner to act as a gatekeeper to coordinate health services. They should be allowed on an ongoing basis to select a 'gatekeeper' from a panel of health practitioners and to appeal to the scheme in the event of dissatisfaction with services provided.

Clinical advisors

The Council is clear that it does not condone interventions from clinical advisors in the management of patients. Nevertheless, clinical advisors are required to be registered with Council or with any healthcare statutory body in South Africa.

Specific practice issues - medical schemes

Access to Clinical Information

Any access to confidential healthcare information about a patient by a third party requires the informed consent of the patient, his/her parent/guardian (if the patient is a minor), executor of the estate/next-of-kin or curator as required by law. Dentists must guard against the rights of individuals being eroded by the possibility of payment being withheld because of non-disclosure.

Accountability (Liability)

Dentists are required to treat their patients with reasonable skill and care.

Where a practitioner's treatment recommendation patient differs from that of the medical scheme or managed care organisation, such recommendation/s must be submitted to the patient in writing to enable the patient to make an informed decision as to the treatment path to be followed.

In these cases where decisions of medical schemes or managed care organisations are not in the patient's best interest and the patient suffers harm as a result thereof, liability should also accrue to the medical scheme involved.

Clinical Guidelines
Health protocols, clinical guidelines and review criteria used by medical schemes and managed care organisations must be developed by health practitioners according to scientific criteria. 3.5.3.2 These guidelines should not be dictated or influenced by managers of HMO.

Contracts
Dentists should ensure that legal, ethical, and clinical norms are adhered to in managed care contracts. The aim should be to strive towards evidence-based medicine and ethical behaviour for the benefit of the patient and cannot enter into contract that transgress the ethical rules or affect the clinical independence and judgement of a health practitioner. The Council has the right to request these contracts.

Cost Saving Benefits
Dentists may be rewarded for delivering quality cost-effective care and saving of costs by educating patients to live healthy lives. However, any cost saving benefits achieved should ultimately be passed on to the patient as the primary sponsor of his/her own care. Incentives can, for instance, be given for using evidence-based medicine and ensuring no under or over-servicing of patients. Cost saving rewards should be subject to independent audit.

Credentialing and Accreditation of Providers
Credentialing and accreditation of a dental practitioner is acceptable provided that both processes are based on objective and transparent criteria such as professional competency, professional qualifications, experience, etc.

Disclosures
Dentists must inform their patients of medically appropriate treatment options regardless of their cost or the extent of their coverage.

Financial Incentives
It is undesirable to enrich a dentist financially or in kind with no evidence based or scientific basis or cost-effective considerations.

Financial incentives should only be used to promote quality and cost-effective care and not encourage the withholding of medically necessary care.

Financial incentives should be allowed to influence dentists and their judgements of appropriate therapeutic alternatives or deny their patients access to appropriate services based on such inducements. Their patients' interests must always come first.

Incentive payments to health practitioner should be based on performance according to criteria that are founded in best practice and ethical behaviour of individuals.

Incentives may not be used to encourage either ‘over’ or ‘under’ servicing of patients. Appropriate care should always be provided.

Formularies
Formularies or restricted medicine lists should be based on best practice principles, that also consider cost-effectiveness.

It is not acceptable to provide financial benefits to providers according to prescriptions based on volume and/or price of formulary medicines.

Dentists are reminded of the Council’s perverse incentive policy.

Preferred Provider Networks
Providers should have the right to participate in any preferred provider network if it meets the criteria of professional qualifications, competence, and quality of care.

These networks should not be exclusive – and that all providers must have the option of being included unless compelling reasons for exclusion exist.

Quality Of Care
In any healthcare delivery system, the emphasis should always be on providing quality care to patients in the most cost-effective way possible. Quality based on best practice may not be sacrificed in the interest of cost. However, quality must be seen in the context of affordability.

Restriction of Choice
3In an ideal health care system, choice should be maximised as it enhances competition. It is however acknowledged that restrictions on the choice of providers, treatment options and/or referrals may be necessary in the interest of access to health care services. It is advisable that a ‘point of service’ option is offered to patients, even at additional cost to the patient.

Risk Sharing
Risk-sharing options between medical schemes and health practitioners, such as capitation, are slowly gaining popularity. This is inherent to managed care provision. Both health practitioner and patients should be thoroughly informed about the risk they assume and should ensure that adequate mechanisms are in place to manage the risk.

Patients must be kept as healthy as possible i.e., through education and preventive measures. Inherent in prepayment arrangements is the risk of ‘under servicing’. Therefore, utilisation reviews, practice profiles and peer review methodologies are prerequisites.

All managed care contracts providing for incentive withholds, i.e., payments for a certain percentage of generic prescriptions – and for payment of fees to providers, should include provisions for an independent audit to ensure timely reimbursement of withholds. The audit should also review whether the amount withheld is appropriate, reasonable and in keeping with the terms of the contract.

Sharing of Fees

Corporate entities are gradually entering the healthcare arena not only as funders of care, but also to deliver health care. This will increasingly challenge the entrenched values of health care practice. Dentists should be sensitive to these developments and ensure that the values inherent to health care practice are not sacrificed and their clinical autonomy not affected by these developments.

These corporate entities typically provide certain management services and infrastructure to providers in return for financial reward, which often amounts to a percentage of turnovers. Charges levied for these services should be based on a previously agreed to rate, and not based on a percentage of the income of the practitioner. The agreed rate may not be based on commission or income.

There is a difference between voluntary arrangements from which the dentist can withdraw if he so wishes and one where his position is dependent on his continued compliance with the organisation's requirements. The latter is not acceptable model of practice.

Utilisation Management
Medical protocols, clinical guidelines and review criteria used by medical schemes and managed care organisations must be developed by health practitioners according to scientific criteria.

Pre-Authorisations
Pre-authorisation procedures should be conducted according to scientifically developed protocols (clinical guidelines) and should include peer-to-peer communication prior to any denial of benefits. The pre-authorisation process should also be a prompt and efficient process.

An appeals process should be available for any provider disagreeing with the medical scheme's/managed care organisation's decision.

Case Management
It is acceptable that one person assumes the responsibility of the overall coordination of the patient care. The dentist is best suited to fulfil this role.

The utilisation of other relevant health practitioners e.g., nurses to coordinate the financial arrangements of the patient, benefit management, high-cost care management, as well as helping with suitable alternative care arrangements on discharge is also acceptable.

Profiling
Profiling of a health practitioner is acceptable provided it is done in a transparent and scientific manner. Health practitioner should be allowed to query their personal profiles and should have the right to understand the criteria used in determining the profile.

Yours in oral health
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