

MDC

MALAYSIAN DENTAL COUNCIL



JUL-DEC 2017
VOL. 13 NO. 2
ISSN 18882-5557

BULLETIN



CODE OF PROFESSIONAL CONDUCT



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President's Message



Fellow practitioners, as we head towards the end of the year, I hope 2017 with its multitude of challenges, has been a fruitful year. I hope you can look back and be proud that, as in previous years, you have provided dental care with the desire to safeguard the health of the patient, promote the welfare of the community and at all times, work to maintain the honour and integrity of the dental profession.

The Malaysian Dental Council has in force the September 2008 version of the Code of Professional Conduct and all registered dental practitioners in Malaysia are bound by this code. The Code concisely outlines the obligations and responsibilities of the dental practitioner to the patient, the dental profession, colleagues and the public at large. Besides that, it also outlines many other aspects of professional responsibility and ethics related to the establishment and maintenance of a dental practice, as well as what constitutes infamous conduct.

It is my fervent hope that all new graduates, numbers of which have increased by leaps and bounds recently, as well as existing practitioners will take cognizance of this "Code of ethics". The dental profession has a long and honourable tradition of service and care, and holds a position of trust and respect in the community. It is the moral duty of all dental practitioners to help maintain this position and not bring disrepute to the profession.

I would also like to take this opportunity to wish all practitioners A HAPPY AND PROSPEROUS 2018. Let us work together to improve the health of our beloved Rakyat.

Datuk Dr Noor Hisham bin Abdullah

From The Editor's Desk



The MDC bulletin went digital in year 2016. Since then the Editorial Board has kept track of its readership. To date there are 489 readers (388 in 2016 and 101 in 2017) for Vol 12 No 1 issue of 2016 Bulletin. Two hundred fifty six (256) dental practitioners accessed Vol 12 No 2 of the Bulletin in 2017. Available statistics for the two months after Vol 13 No 1 of the Bulletin was uploaded indicate that it was accessed by 101 practitioners. It is still too early for us to gauge the response to the digital format of the Bulletin. We will keep you updated.

The recent prosecution of a bogus dentist who was issuing 'fake braces' and the public rallying to raise money to settle the fine imposed by the court, has generated widespread interest among netizens. Not many practitioners are aware that there have been numerous other dentally related cases that have been brought to court in Malaysia. This issue of the Bulletin highlights the various types of cases that have been prosecuted or are pending in the courts over the past several years.

The placement of implants is becoming more common among practitioners. There are no restrictions on general practitioners engaging in this practice, provided they have adequate training and skill to insert these implants. Although such procedures bring high returns to the practitioners, they carry high risks if not undertaken properly. This may result in expensive law suits and/or dental malpractice claims. Although implant dentistry constitutes only a small proportion of procedures undertaken in practice, it accounts for a relatively high total claim expense in some countries. As negligence claims can result from an error of omission or commission, we feature an article on the Do's and Dont's of implant dentistry in this issue.

The Malaysian Dental Council has a right to take action against any dental practitioner who is registered with it for unethical and unprofessional behaviour. But before doing so, any complaint or information received against a practitioner will be scrutinized by the Preliminary Investigation Committee (PIC), which will examine the complaint or information received, as well as the explanation of the defendant dentist to determine whether or not there is a prima facie case for a formal inquiry by the Council. In undertaking this heavy responsibility, the PIC faces numerous challenges to ensure that all parties are heard fairly. The roles, responsibilities and challenges faced by the PIC is also featured in this Bulletin.

Happy reading.

Prof Dato' Dr Ishak Abdul Razak

ROLES, RESPONSIBILITIES & CHALLENGES

of the Preliminary Investigating Committee

by

Datuk Dr N Lakshmanan

Chairman of Preliminary Investigating Committee (PIC) 2

My dear colleagues, in my opinion facing a case at PIC should not be construed as being guilty of a wrong doing. It may just mean that your practice needs some improvement. I must further emphasise that the patient is not always right, neither on the other hand is the practitioner always right.

ROLES

The role of the PIC is to carry out investigations to assess the conduct of dental practitioners, judged by their peers in the profession. The PIC, under the authority of the Council, considers whether there is any breach in standards, which will fall under the categories of Neglect of Responsibilities, Abuse of Skills, Derogatory Conduct and Advertising & Canvassing. The PIC, being an independent entity, conducts its inquiries independently.

RESPONSIBILITIES

The preliminary responsibilities of the PIC include identification of all parties, informing them of their rights and maintaining decorum at the highest standards. The members of a PIC should adhere to punctuality, dress codes and procedures at all times. After the preliminaries are over, the PIC proceeds to find out if there are sufficient grounds to support the allegation. If there are, then a charge will be framed. The

practitioner is then at liberty to state his defence to the charge framed against him. If the practitioner chooses to defend himself, the PIC shall record his statement word for word. After his statement in defence, the PIC may recommend to Council that no action be taken or to hold an inquiry, based on whether or not they feel there are sufficient grounds to support the charge.

During PIC meetings distractions are common, often when one party wants to prove an irrelevant point. These should be nipped in the bud. In the interest of all parties, a case should be completed, as far as possible, within a year, and this should be emphasised both to the complainant and the practitioner. We are among equals and should avoid outside influence or interference. The facts in issue should be specific and explicit. Rules of Natural Justice have to be observed at all times. Both parties should be treated equally and copies of all documents should be furnished to both. Finally Justice should be meted out fairly to both parties.

CHALLENGES

The challenges faced by a PIC can usually be overcome by proper management.

- Quorum. The rule disallowing new members or members who were not present at any one hearing of the inquiry from future hearings makes maintaining a quorum difficult.
- Postponements. Calling off an inquiry due to non-attendance of the complainant is a ma-

for issue.

- Relevant facts. Sieving out and disregarding irrelevant details that may emerge at examinations and cross-examinations is essential.
- Withdrawal of Complaints. The complainant may withdraw the complaint in writing before the conclusion of the inquiry.

Today the doctor-patient relationship is complex, and our patients think differently. Some hints:

- Have a list of charges displayed even if it looks like a menu card.
- Above and beyond your goodness and mastery of your skill, be polite.
- Believe it or not we are so used to stress that we fail to recognise it and hence even the best of us succumb to errors.
- Trust your colleagues more than your pa-

tients.

- Don't expect to be treated like a demi god.
- Tell patients that treatment is as per current standards and their body might respond adversely. Prime them for realistic expectations.
- Finally enjoy practicing dentistry.

It is an honour and a privilege to serve on a PIC. When serving on a PIC, humility is of the utmost importance. We are not there to find fault. We are not there to defend our colleagues. We are there, at the will and pleasure of the DG, to uphold professional standards, which we all are proud of and have a responsibility to maintain.



DISCIPLINARY PROCEEDINGS

by Dr Norfarhana bt Md Daud

FACTS OF THE COMPLAINT

- a) A complaint was received from Dr A, an enforcement officer with Jabatan Kesihatan Negeri Z against Dr B, a private dental practitioner, for knowingly allowing an unregistered person to practice dentistry at his place of dental practice.
- b) On XX February 2015, Dr A joined the raiding team formed by Unit Kawalan Amalan Perubatan Swasta (UKAPS).
- c) During the raid, the team found an Indian national in the first surgery with two Chinese ladies, one of whom was the patient and the other admitted to being the dental surgery assistant. The Indian man attempted to run away, but he was prevented from doing so with the help of the staff from the Immigration Department.
- d) In the second surgery, Dr B was treating a patient with an assistant. She was later identified as the owner and the person in charge of the clinic.
- e) During the investigation the Indian man was unable to produce his Practising Certificate and informed the Investigating Officer that he had not registered with the Malaysian Dental Council.

FINDINGS OF THE PRELIMINARY INVESTIGATION COMMITTEE (PIC)

Based on the oral evidence, witnesses and supporting documents available, the PIC found that:

Dr B knowingly allowed an unregistered person to practice dentistry at her place of dental practice.

DR. B'S EXPLANATION

Dr B pleaded guilty to the charge during Day 3 of the inquiry.

VERDICT OF THE COUNCIL

The Council found the practitioner guilty of the charge and the practitioner was suspended from practice for a period of one year under Section 33 (1)(b).

CHARGE AGAINST THE RESPONDENT

Dr B knowingly allowed an unregistered person to practice dentistry at the said place of dental practice. In that respect she failed in her responsibility to ensure the safety of the patients by employing an unregistered person to practice at the said place of dental practice.

In relation to the facts alleged, Dr B may be found guilty of infamous conduct in a professional respect under section 32(2)(b) of the Dental Act 1971, which is punishable under Section 33 of the Act.

RECOMMENDATION OF PIC

After taking the practitioner's statement, the committee unanimously agreed that there is a case to answer to the charge and recommends to Council to hold an inquiry as provided for in Regulation 29 (Dental Regulation 1976).

DENTAL ENFORCEMENT ACTIVITIES

UNDER THE PRIVATE HEALTHCARE FACILITIES AND SERVICES ACT 1998

(until 30 June 2017)

by Dr Elise Monerasinghe

Enforcement in private dental clinics officially began in 2006, with the implementation of the Private Healthcare Facilities and Services Act 1998. At that time there were over 1,000 existing clinics to be registered, and all the enforcement activities were directed at carrying out the pre-registration and post-registration inspections of private clinics and hospitals. All the existing clinics were registered by 2009, and it was only after all the inspections were completed was there time and manpower for enforcement against illegal practice.

Enforcement activities, while co-ordinated by the Oral Health Division, is carried out by the state enforcement units and all the enforcement activities have been combined operations by at least 3 states. Below are the enforcement activities carried out by the state enforcement units together with officers from the Oral Health Division.

Most of those who were prosecuted have been Malaysians, except for 2 Myanmarese, 3 Indonesians and 1 from India.

While the issuing of 'Fake Braces' is an illegal activity, it has been reported separately here as this phenomenon is becoming more rampant and requires special attention.

Year	No. of Raids	Type of Cases	Punishment
2008	1	Unregistered clinic	Fined RM9,000
2011	1	Illegal practitioner	Fined RM20,000
2012	1	Illegal practitioner	Fined RM120,000
2013	5	Illegal practitioners (4)	Practitioners absconded
		Practising while suspended	Fined RM10,000
2014	3	Illegal practitioner (1)	Fined RM20,000
		Fake braces (2)	Fined RM20,000 Absconded



Year	No. of Raids	Type of Cases	Punishment
2015	9	Illegal practitioners (7)	Fined RM20,000 Fined RM25,000 Fined RM30,000 Fined RM35,000 Absconded (3)
		Fake braces (2)	Fined RM25,000 Fined RM30,000
2016	9	Employing an unregistered practitioner	Fined RM30,000
		Fake braces (8)	Fined RM15,000 Fined RM25,000 (2) Fined RM30,000 + 1 month jail Fined RM40,000 Fined RM250,000 / 5 months Absconded Pending in court
2017	12	Illegal practitioner (2)	Absconded Pending
		Fake braces (10)	Fined RM300,000 / <u>3 mths</u> Fined RM40,000 Fined RM250,000/ <u>12 mths</u> Fined RM70,000 / 6 mths Fined RM200 (Juvenile) Absconded (1) Pending in court (4)

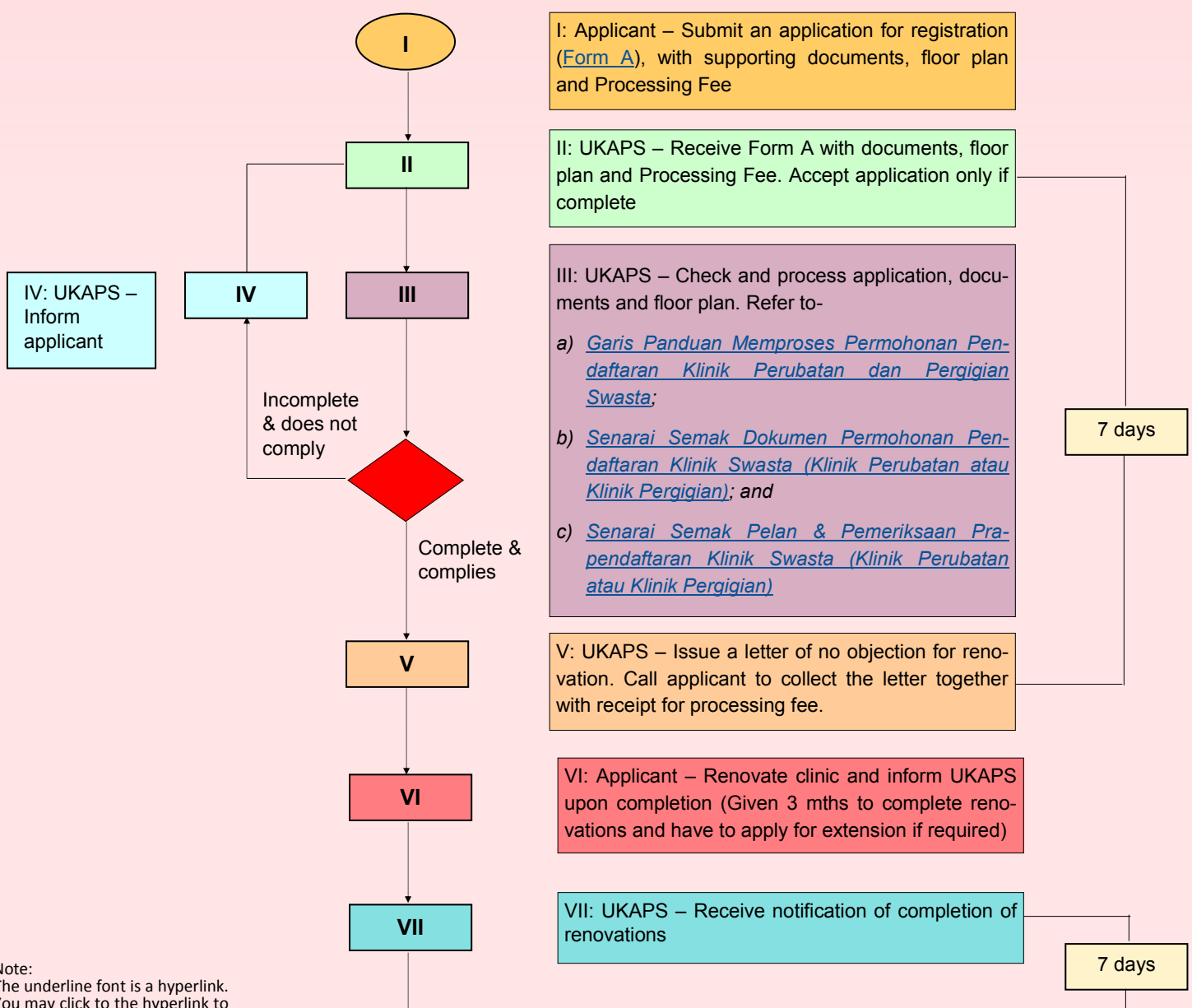


PRIVATE CLINIC REGISTRATION PROCEDURE

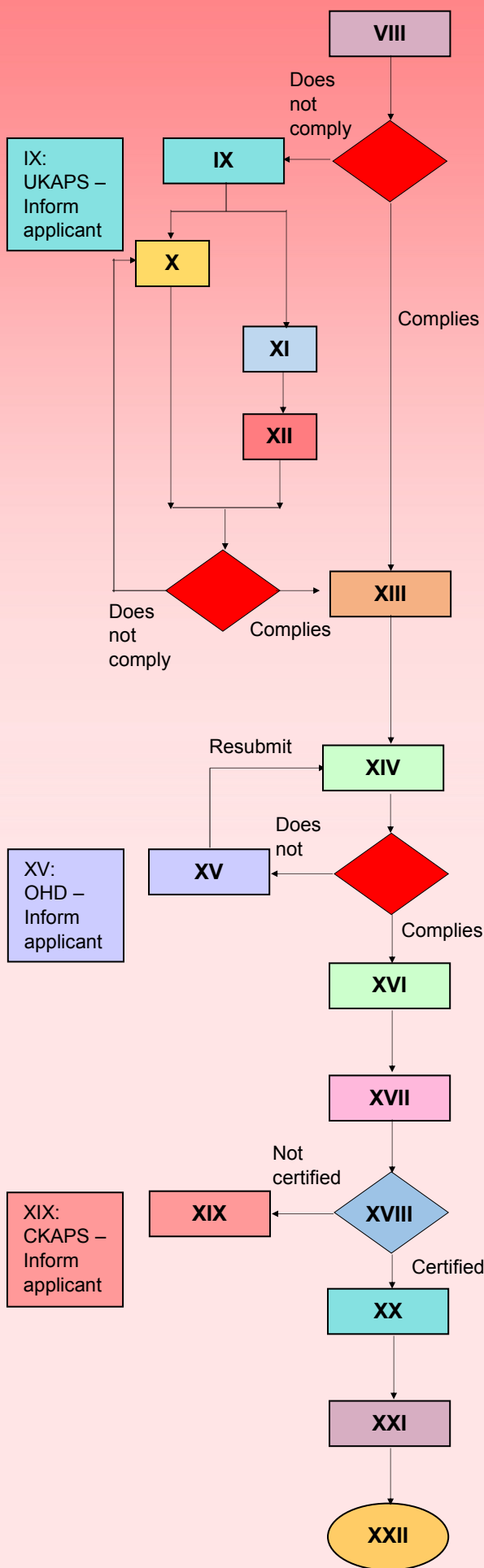
by Dr Haznita bt Zainal Abidin

The main purpose of the registration process is to ensure that the facility, equipment and practitioners are appropriate for the services to be provided by the private clinic, so as to ensure patient safety and quality of health care in accordance with set quality standards.

This flowchart provides guidance on the procedures for application for a Certificate of Registration of a private dental clinic. It must be noted that there might be slight variations from state to state depending on local government requirements.



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You may click to the hyperlink to view the document.



VIII: UKAPS – Carry out pre-registration inspection with appointment (Refer [Senarai Semak Pelan lantai & Pemeriksaan Pra-pendaftaran Klinik Swasta \(Klinik Perubatan atau Klinik Pergigian\)](#)).

X: UKAPS – Receive photographic evidence of improvements

XI: UKAPS – Receive notification of improvements carried out

XII: UKAPS – carry out surveillance inspection

XIII: UKAPS – Submit application, pre-registration inspection report, photographs & recommendation (from PKN) to CKAPS

XIV: OHD – Check details of application, documents and floor plan

XV: OHD – Inform applicant

XVI: OHD - Present application in Appraisal Committee Meeting

XVII: CKAPS – Send recommendation to DG of Health

XIX: CKAPS – Inform applicant

XVIII: DG of Health – Considers application for certification

XX: CKAPS – Issue letter to applicant requesting Registration Fee & document (e.g. APC)

XXI: CKAPS – Receive Registration Fee and documents. Prepare Certificate of Registration (Form C)

XXII: CKAPS – Issue Certificate of Registration to the applicant

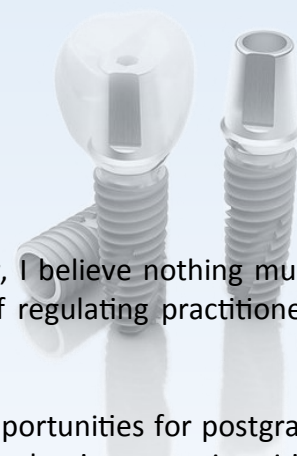
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Risk Management In Clinical Practice

Navigating The Minefield of Dental Implantology

By Prof. Dr. WC Ngeow,
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Dental implantology has taken the world by storm since the first commercial implant was marketed in the 1970s. Previously, implant dentists had to undergo rigid training and follow strict protocols, with the oral and maxillofacial surgeons being the driving force behind implant fixture placement. Throughout the last 4 decades, the landscape has changed tremendously, and dentists now place dental implants in their offices as part of their routine dental service. However, one peculiar feature of implant dentistry is that most of the dental education and training related to it was strongly supported by the industry, instead of being a core teaching in any academic institution¹. One will notice that previously there were more implant courses offered in a year by dental implant manufacturers and suppliers/distributors than in institutes of higher education.

Due to this, a working group of the General Dental Council (GDC) of the United Kingdom in 2005 produced recommendations on *Training standards in implant dentistry for general practitioner*. Among others, it stated that general dental practitioners (hereafter termed “dentists”) should complete a course in implant dentistry and undergo mentoring ‘until the experienced implant clinician considers the practitioner to be competent.’ It also recommends that all dentists keep a detailed portfolio of their training, their mentoring and an audited record of the implants they have placed. At that time, the GDC was considering further measures to regulate dentists’ practice in skills significantly beyond those acquired in their primary qualification. In fact, three years later the GDC went as far as to issuing a warning to dentists due to concern for their lack of super

vised training². However, I believe nothing much has changed in terms of regulating practitioners since then.

Over the last decade, opportunities for postgraduate education in implant dentistry at universities have increased tremendously, both in terms of the number and the complexity of the training programmes³. However, there appears to be a lack of standardized requirements relating to the learning outcomes of these programmes, although Donos *et al.* vigorously outlined the competencies and the appropriate postgraduate educational pathways in implant dentistry some 8 years ago⁴. Mattheos *et al.* reported that many university programmes concluded with a master’s or equivalent degree, but with a wide range and great variation in the duration and learning objectives, targeted skills and competences. They found that there was little indication of the comprehensiveness of training, even in established specialist training programmes.

Implant failure (be it osseointegration or the prosthetic components) and complications have continuously been reported irrespective of the training background of the practitioners^{5,6,7,8,9,10,11}. This may result in law suits and/or dental malpractice claims. In the USA, implants made up approximately 5% of dental malpractice claims in 2006¹². The average of paid-out dental claims (not limited to implant dentistry) in the USA ranges from USD 30,000 to USD 50,000. Unfortunately, claims related to implants often have a high degree of severity (dollar value). According to the CNA Health Pro (<https://www.cna.com>), a company with more than 50 years of experience in insurance for healthcare facilities and providers

in the USA, although only slightly more than 3% of all reported dental claims between 2004-2007 involved dental implants, these claims have accounted for more than 7% of total claim expenses. This is because of the frequently high cost of complex corrective treatment needed to return patients to their preoperative status.

Dental Protection Limited of the United Kingdom published a risk management module '10: implants' several years ago, and summarized the 4 most common allegations related to negligence claims arising from implant treatment. They are:

- Inadequate case assessment, investigations, or consent (28%)
- Unsatisfactory aesthetics or function (27%)
- Implant failure (due to biological causes or system designs) (22%)
- Damage to surrounding structures (e.g. inferior dental nerve, mental nerve, lingual nerve) or complications involving the maxillary sinus (14%).

Similarly, CNA Health Pro reported the same range of issue, but they named permanent paraesthesia or the need for corrective surgery (allegedly due to the improper placement of the implant into a vital structure such as a sinus or nerve bundle) as costly major errors. Other so-called less serious errors, which cause less bodily harm to patients, resulted from inadequate treatment planning with the consequence of patient dissatisfaction. Examples given were situations where there was an inability to use a fixture because the implant was allegedly placed at a poor angle, too close to a natural tooth, too close to another implant, or was the wrong length or diameter, or the design was incorrectly selected.

Past experience with expensive claims, has caused most recent implant training courses to put a lot of emphasis on avoiding potential injury to the trigeminal nerve branches. This is because implant treatment has been reported to cause temporary paraesthesia in up to 43.5%, and persistent problems in up to 13% of patients. The number of malpractice suits has increased significantly with

awards being among the highest in dentistry^{13,14,15,16}. Interestingly, an article that reviewed the medicolegal aspects of altered sensation following implant placement in the mandible, reported that specialists are as "guilty" as general dentists. They caused half of the cases with persistent numbness while the remaining half was the result of implant placements performed by dentists¹⁷. Several highlights of this report include

- a. a wide duration in time to filing of claims that ranged from 0 to 60 months (mean 21.5 months);
- b. the implant length was equal to or longer than 13 mm in 6 of 7 implants placed in the molar region, and in the premolar area, nerve injury was evident in 6 of 7 cases where implants shorter than 12 mm were used.
- c. Dental panoramic tomography was used in 15 cases, while in 1 case, only a periapical radiograph was taken. In the 15 cases, postoperative imaging demonstrated a violation of the mandibular canal by the implant, while the remaining one was a result of instrumentation during preparation of the implant site.

A recent survey in the United Kingdom reported that inadequate radiological assessment was the most common cause of trigeminal nerve injury¹⁸. Mind you, this happened prior to the availability of cone-beam computerised tomography, hence the dentists or specialists was not able to view the 3 dimensional appearance of the mandible for treatment planning. Currently, the American Academy of Oral & Maxillofacial Radiology recommends that cross-sectional imaging be used for the assessment of all dental implant sites with CBCT being the imaging method of choice¹⁹. Chaushu *et al.*'s report, which reviews liability claims of 61 cases related to implants between 1992-1999, confirms the fear of Mattheos *et al.* regarding the quality of training at both general practitioner and specialist levels.

Kan published an excellent article on the medicolegal aspects of dental implants in the Hong Kong Dental Journal in 2005²⁰. In it, he stated that a dentist who fails to demonstrate all the requisite skills to perform implant treatment for a particular patient, is at risk of being found negligent in rela-

tion to that treatment. Furthermore, he emphasized that there is also a risk that the dentist may be found guilty of misconduct in a professional respect in the event that the patient makes a complaint to the Dental Council. Although this publication pertains to dentists practicing in Hong Kong. It is believed that a similar professional expectation is practiced by our Malaysian Dental Council. Kan's article also listed the need for proper pre-treatment investigations and selection of implant materials, obtaining informed consent and recording in detail all stages of treatment. This article is downloadable from the website of the Hong Kong Dental Association, and makes a good read for those who wish to go into the details of the medico-legal aspects of dental implants.

Cheung, the then Chairman of the Patient Complaints Mediation Committee of the Hong Kong Dental Association stated, in the same journal, that it is important to identify and discuss potential failures (besides surgical risks) with patients, to ensure that patients have realistic expectations before treatment is started²¹. Patients should know that implant treatment is not a one-glove-fits-all type of treatment. He stressed that dentists should put a lot of emphasis on treatment planning by considering the patient's systemic and implant site conditions in addition to the proper prosthetic design. He summarized 6 important points to remember from the perspective of risk management²². They are:

- a. Careful evaluation of the patient's medical condition and suitability for implant treatment;
- b. Taking the necessary precautions to minimize the risk of failure;
- c. Identifying factors that may hinder success and informing the patient of how they may affect outcome;
- d. Obtaining informed consent from the patient as part of the treatment record;

- e. Acquiring and developing the necessary clinical skills in both surgical and prosthetic treatment; and
- f. Suggesting a maintenance protocol designed to achieve long-term success.

A similar reminder was given by Palmer in one article in the series on Risk management in clinical practice published in the British Dental Journal, which is currently downloadable from its website²³. In Part 9. Dental implants, he outlined the need to carry out a comprehensive examination and diagnosis, in order to ensure that a suitable patient receives dental implants. He even outlined the number, size and spacing of dental implants in different types of edentulous jaws. He ended the article with the following advice to dentists²⁴:

- a. Obtain adequate training and work within their level of experience and skill;
- b. Evaluate and plan treatment carefully;
- c. Communicate with the patient and the dental team, especially a highly skilled technician;
- d. Document carefully and retain all relevant radiographs and casts;
- e. Adopt protocols that are proven and predictable without cutting corners;
- f. Provide a high level of care and skill; and
- g. Refer patients that are too complex.

In conclusion, the success or failure of one's implant treatment boils down to proper case selection and performing procedures within the capability of one's training. Implant dentistry is one branch of dentistry that requires a lot of mentoring as it involves applying surgical, periodontal and restorative knowledge, all on the same tooth. For those who are already providing or are planning to provide this treatment option, all the best in navigating the minefield of dental implantology, while you strive to raise the level of dentistry in this country.

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