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AN MDDUS
PUBLICATION





Welcome to your SoundBite

SOCIAL media is used by millions of people and dentists are no exception. But as professionals, there are added risks to consider before logging on to post a comment or picture. My article on [page 4](#) looks at issues of privacy, confidentiality and professionalism and how to help avoid getting in trouble with the General Dental Council.

Starting out in dental practice can be daunting, but MDDUS' new early practitioner adviser Laura McCormick – an experienced dentist – is on hand to help. Her article on [page 6](#) offers practical advice on matters such as contracts, tax, and practice systems. One vital requirement for dentists is securing appropriate indemnity cover. With so many myths flying around, MDDUS dental adviser Claire Renton sets the record straight on [page 10](#).

The GDC has faced criticism in recent years over its effectiveness, but could the introduction of case examiners be a sign of positive progress? Find out more in our article on [page 7](#).

Dental student Salman Sheikh faced many challenges during his volunteer work in the refugee camps of Calais. He talks about his experiences on [page 12](#). Those with a keen interest in academic study might enjoy a career in oral and maxillofacial pathology. Find out more about this small but fascinating specialty on [page 8](#).

A dental student on a boisterous night out with friends lands herself in professional difficulties in our case study on [page 14](#).

• Sameera Teli
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GDC INDEMNITY DECLARATION

DENTISTS registering to pay their annual retention fee with the General Dental Council are reminded they are now required to declare they have full indemnity in place – or will have by the time they start practising.

MDDUS would like to reassure members that this is not a new requirement as dentists have always needed appropriate indemnity in order to practise dentistry. The only difference now is that practitioners must complete an indemnity declaration as part of their annual renewal process.

The GDC does not require registrants to provide an indemnity certificate unless specifically requested for further information. However, practising without appropriate indemnity in place is contrary to guidance and can result in a fitness to practise investigation.

Practitioners who are covered by their employer should check they are indemnified prior to their declaration and not assume their employer will make arrangements for them.

MDDUS members receive a proof of indemnity certificate once the first direct debit is taken, usually around the renewal date. They can also request a PDF copy at any time by emailing our membership team on membership@mddus.com

The GDC registration window is open now until midnight on December 31, 2016.

The regulator is encouraging clinicians to logon to the eGDC portal to make their indemnity declaration, pay the annual retention fee (ARF), declare CPD hours and update personal information.

ORAL CANCER ON THE RISE

MOUTH cancer rates in the UK have risen by 68 per cent over the last 20 years, according to new analysis from Cancer Research UK.

The number of cases increased from eight to 13 per 100,000 people over the last two decades.

Oral cancer is more common in men, and for those under 50 the rate has risen by 67 per cent in the last 20 years – increasing from around 340 to around 640 cases each year. For men aged 50 and over, rates have increased by 59 per cent climbing from around 2,100 cases to around 4,400 cases annually.

Similar rises have been seen among women, with oral cancer rates increasing by 71 per cent in the last 20 years for women aged 50 and over, jumping from 1,100 to around 2,200 cases a year.

Oral cancers include cancer of the lips, tongue, mouth (gums and palate), tonsils and the middle part of the throat (oropharynx). Around 90 per cent of cases are linked to lifestyle and other risk factors. Smoking is the biggest avoidable risk factor, linked to an estimated 65 per cent of cases. Other risk factors include alcohol, diets low in fruit and vegetables, and infections with the human papilloma virus (HPV).

Cancer Research UK and the British Dental Association have developed an oral cancer toolkit (tinyurl.com/nt8jsfv) to help GPs, dentists, nurses and hygienists spot the disease and refer suspected cases sooner.



REVISED TRAINING STANDARDS FOR IMPLANTS

NEW revised training standards for implant dentistry have been published by The Faculty of General Dental Practice (UK).

This new edition of the standards document aims to provide a summary of the training that a reasonable dental practitioner carrying out safe implant dentistry in the UK should undertake before embarking upon patient care in this discipline.

FGDP(UK) Vice Dean, Abhi Pal, who led the working group that updated the standards, said: "Raising the standard of implant training courses will ensure that practitioners are skilled, knowledgeable and confident in their work, and patients are provided with safe and reliable treatments in this high profile and high cost dental discipline."

Training Standards For Implant Dentistry is available to download at www.fgdp.org.uk as a part of the Open Standards Initiative.

- The FGDP has also produced a toolkit for dentists to help reduce antibiotic prescribing. Since 2015, dentists and other healthcare providers have had a statutory duty to reduce the risk of antimicrobial resistance by ensuring appropriate use of antibiotics. Download the toolkit free on the FGDP website at tinyurl.com/zdtwrd3

FREE CAREER ADVICE FOR NEW DENTISTS

AT MDDUS we recognise that starting out as a dentist can be a daunting prospect. Now dental members practising in Scotland can take advantage of a great new service designed especially for those beginning their careers.

MDDUS Early Practitioner Adviser, Laura McCormick, is now on hand to offer advice on topics such as what to expect from practice life, how to choose the right job or understanding associate agreements.

Laura is a practising dentist who has worked as a VT trainer and also as a coach and mentor for the Training Revision and Mentoring Support

(TRaMS) programme. She has the experience and expertise to provide recent graduates with educational support and insight into working life.

This great new service is provided at no additional charge for MDDUS dental members who are practising in Scotland and have graduated within the past five years. Contact Laura at lmccormick@mddus.com. Read her advice article on page 6.



WARNING OVER COUNTERFEIT DENTAL DEVICES

DENTISTS are being warned over the risks of buying non-compliant and counterfeit dental devices online.

More than 1,900 such devices have been seized in the last year by the Medicines and Healthcare products Regulatory Agency (MHRA), including dental hand pieces, dental surgery equipment and drill bits.

The MHRA has highlighted the "rapid growth" in websites offering cheaper equipment but warned some of those being sold have not been properly tested and are not authorised for use in the UK dental sector.

The agency has teamed up with the British Dental Industry Association (BDIA) to warn of the risks of buying substandard devices and to raise awareness of the dangers they present to both patients and clinicians.

Cheaper devices sold online can break and shatter while in the mouth with the potential to cause "horrific" damage to teeth and gums.

Medical device adverse incidents can be reported via the Yellow Card scheme.



NEW FACULTY OF DENTAL TRAINERS LAUNCHED

A NEW Faculty of Dental Trainers has been established by the Royal College of Surgeons of Edinburgh.

It is the first of its kind in the UK and will focus on promoting, recognising and rewarding teaching, training and education in dentistry. It is intended to provide a framework to promote and guide dental trainers throughout their educational careers.

The faculty will be open to all qualified members of the dental team working in the UK and internationally: dentists, dental nurses, dental hygienists, dental therapists, technicians and orthodontic therapists who can demonstrate their involvement in appropriate dental training. It will provide support and guidance for career development in dental training, as well as establishing a platform for recognised dental trainers.

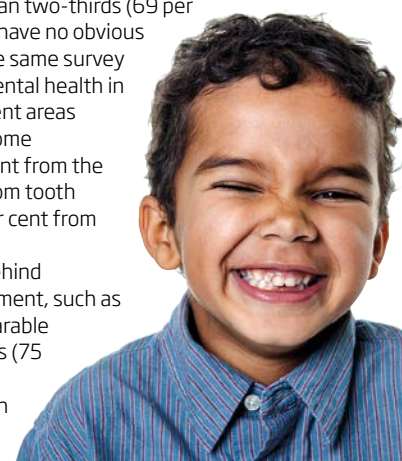
The new faculty will offer three levels of membership: Associate, Member (MFDTEd) and Fellow (FFDTEd).

SCOTLAND STILL PLAYING "CATCH-UP" ON CHILDREN'S DENTAL HEALTH

DENTAL health among children in Scotland has improved by 24 per cent since 2000 but the high levels of social inequality in dental care are still unacceptable, says the British Dental Association.

New figures from the National Dental Inspection Programme in Scotland show that more than two-thirds (69 per cent) of five-year-olds now have no obvious signs of tooth decay. But the same survey also reveals a huge gap in dental health in P1 children from more affluent areas compared to the lowest income households - with 55 per cent from the most deprived areas free from tooth decay compared with 82 per cent from the least deprived.

Scotland also still lags behind countries of similar development, such as England and Norway. Comparable figures show that two-thirds (75 per cent) of five-year olds in England are decay-free, with broadly similar figures for Norway (73-86 per cent).



SoundBite editor **Sameera Teli** explores the pitfalls of dentists using social media

THE ONLINE DENTIST

SOCIAL media is part and parcel of our daily lives, serving as a useful source of information and entertainment as well as a means of global communication for millions. Dentists are no exception to this trend and sites such as Facebook and Twitter have become valuable platforms for sharing tips, ideas and innovations. But our duty to maintain professional standards – both online and offline – means there are added risks to consider before logging on.

Social commentary

Gone are the days when the only form of online communication was the humble email. In addition to the two big ones mentioned above, there are now countless networking sites available including Instagram, LinkedIn, Google+ and Pinterest, not to mention various other blogs and forums. I think the majority of us, especially younger dentists, would admit to having accounts on at least two or more of these.

In November 2014 the *British Dental Journal* published the findings of a US study into social media usage amongst dental students which revealed a massive 91 per cent used Facebook. And one of the greatest barriers to usage cited by respondents was privacy concerns.

Social sites are effective avenues for communicating professionally and personally, however it has become a much more exposed place where information is instantly available for all to see. It is easy to make an impulsive negative comment that we may later regret (or not actually believe at all). While spoken words can be quickly forgotten, the same does not apply online where it is much more difficult to entirely erase written comments. They often linger in a search history cache or may even have been captured in a screenshot.

A good example of the potential risks is shown in the case of a dental nurse who in July 2015 posted a Facebook message that indirectly supported an act of sectarian violence. The comment made no mention of her job but resulted in a complaint to the General Dental Council (GDC). She was called before the Professional Conduct Committee (PCC), who decided that her post violated the GDC standard 9.1.3: "You should not publish anything that could affect patients' and the public's confidence in you, or the dental profession, in any public media". The nurse's fitness to practise was found to be impaired and she was given a reprimand.

The latest GDC guidance on using social media (tinyurl.com/jpgjvzr), published in June 2016, echoes this stance, advising that "you should not post any information, including personal views, or photographs and videos, which could damage public confidence in you as a dental professional."

Some social sites, including Facebook and Instagram, do allow users to modify privacy settings around who can see your posts or uploads. However this does not eliminate risks entirely. Posts will still be accessible to your existing contacts and, as already mentioned, it only needs one person to take a screenshot for that information to spread



more widely. Likewise, posting anonymously or under an assumed name is also no guarantee of protection.

A recommended approach is to assume that everything we post could potentially be viewed by anyone – including patients, colleagues, patients, employers and regulators. So if you wouldn't say it to them directly, then don't say it online.

Confidentiality

Online forums have become a popular means for professionals to discuss best current practice and clinical cases. This generally takes place within private login-only sites that require some kind of dental credentials. But despite the supposed private nature of such sites, information may still fall into the wrong hands. Clinicians should take great care regarding patient confidentiality and only share anonymised information unless the patient has given their explicit consent otherwise. This would apply to the likes of clinical records, radiographs, photographs, video and audio recordings.

The GDC advises: "If you are sharing anonymised patient information, you must also take all possible precautions to make sure that the patient cannot be identified. Although individual pieces of information may not breach a patient's confidentiality on their own, a number of pieces of patient information published online could be enough to identify them or someone close to them."

Before considering publishing identifiable information, familiarise yourself with the GDC's *Standards* guidance on confidentiality (Standard



"You must maintain appropriate boundaries in the relationships you have with patients"

4.2) and proceed with extreme caution. Broadly, when gaining patient consent to share their information, it is important the patient fully understands:

1. The content being released and how it may be used
2. The reason for sharing the information
3. Where the information will exist
4. The likely outcomes of releasing the information.

A record should also be made of whether or not the patient gave their permission.

Patient dialogue

Many dental practices set up corporate accounts on the likes of Facebook or Twitter as a means to post relevant patient announcements or other useful information, with some also inviting patient feedback. Any practice account of this kind should state clearly that social media is not an appropriate means for patients to seek clinical help, and instructions for doing so (i.e. the practice phone number) should be posted prominently to avoid confusion.

While inviting patient views may prove useful, bear in mind that this can generate both positive and negative comments. Any dental professional unfortunate enough to receive an online patient complaint should think carefully before responding and it is advisable to first contact your dental defence organisation for advice.

Patient friend request

Another important question for dentists using social media is: "What do you do if a patient sends you a Facebook friend request?" Or if they want to engage with you on any form of social media? A recent poll by GDP UK looking at the use of Facebook amongst dentists found that 72 per cent of them had a personal account. Of those, 47 per cent said their profile was public or only partially private and 31 per cent admitted to accepting one or more patient friend requests.

The GDC advise: "You must maintain appropriate boundaries in the relationships you have with patients. You must not take advantage of your position as a dental professional in your relationships with patients." They say dentists should "think carefully" before accepting friend requests from patients. MDDUS Head of Dental Division Aubrey Craig goes one step further and advises dentists to "politely decline" any such request, explaining the need to maintain professional boundaries.

As before, use your profile privacy settings to make your account as secure as possible. Facebook allows users to block their profile from public searches which may help reduce contacts from patients.

Social media will continue to be an inseparable and positive part of all of our lives. We should think carefully before acting online, in order that we maintain our patient's trust in us as dentists and in our profession as a whole.

Sameera Teli is a dentist and editor of SoundBite

OFF TO A **FLYING** START

Starting out in dental practice can be daunting, but new MDDUS early practitioner adviser **Laura McCormick** is here to offer some words of advice

CONGRATULATIONS! All your hard work has paid off and you are about to embark on a career in dentistry.

The early days in practice are exciting but they can also be challenging as the realisation of the responsibility that you now carry begins to sink in. There is a lot of new information for you to take on board and an ever-growing mountain of paperwork to deal with. And you thought all you had to do was teeth...

Speaking to recent graduates, the amount of new information to absorb can be overwhelming. So what do you need to deal with?

Read the contract

When you have successfully secured your perfect job in your ideal practice you need to ensure that you have a contract with the practice. You must ensure the points discussed during your recruitment are documented as agreed and that there are no surprises. Therefore read the contract before you actually start working in the practice. I have taken calls from dentists who have turned up at the practice on their first day and were presented with a contract that bore no resemblance to what they had previously agreed. Fortunately this scenario is rare, but why take the chance?

Tax receipts

In most practices the associate arrangement is still the most common. This means that you are classed as self-employed for tax purposes. It pays to be organised: keep all receipts (preferably in order), keep a note of everything and put money aside for tax every month. Speaking to new associates this was the piece of advice that was repeated to me several times. It is not as exciting as splurging on designer clothes but it is much easier to put money aside than to try and find money for your tax bill. This is especially true in January,

just after Christmas and paying the GDC. A good chartered accountant will keep you right.

Right numbers

If you are providing dental treatment within the NHS you will require a list number from the health board area under which you will be working. You must have this number before you can start work. You will also require an electronic data interchange (EDI) number so that you can transmit the claim forms electronically and you must have signed the mandate if you want to be paid for any work.

Know the SDR

The SDR (Statement of Dental Remuneration) is the foundation of NHS dental treatment provision. It not only contains the fees for treatment that can be carried out, but it also provides information on allowances, e.g. CPD and audit. There is no avoiding it, you must know the SDR. I'm not suggesting you sit down of an evening and tackle it in one sitting. The best way to read it is in small sections armed with a pen and paper so you can write in simple terms your interpretation. Don't just focus on the item codes and fees but also on the provisos as these lay out the circumstances under which you can provide treatment, e.g. time bars affecting periodontal treatment or items marked with an asterisk* require prior approval. Prior approval, or PA, is the authorisation to proceed with a proposed treatment plan. It relates not only to items with an asterisk but also has a monetary value of treatment required. You must be able to justify the proposed treatment and demonstrate the treatment will secure and maintain the oral health of the patient. The Practitioner Services Division (PSD) website is a good source to find the information required to help your PA requests go through the system smoothly.

By knowing the SDR you are ensuring that

you will be claiming correctly and that you will receive payment for the treatment you have carried out.

Practice systems

You will also need to be familiar with the practice management system, as each practice will be different. Questions to ask include: how are patients who fail to attend their appointment followed up? How many FTAs occur before the form is finished? The answers to these questions are crucial to ensuring that your forms are submitted within the three-month timeline for payment.

So that's all in order, where is the high speed? Not yet. Are you sure that the instruments you are about to put in a patient's mouth are adequately cleaned? As a clinician you are responsible for what you use in a patient's mouth. Therefore do you know what happens to the instruments before they magically appear clean and shiny on your bracket table? What is the practice decontamination process? Would you be happy to have treatment in your own chair?

Another important question to ask is where are the emergency drug kit and oxygen kept? It is much better to take the time to know where these are located rather than wait for a medical emergency and the unsettling panic that will take over when you realise that you don't know where these things are.

It can sometimes feel that you are spending more time asking questions and reading than actually treating patients but it pays to be organised.

Are we ready for Mrs Smith now?...

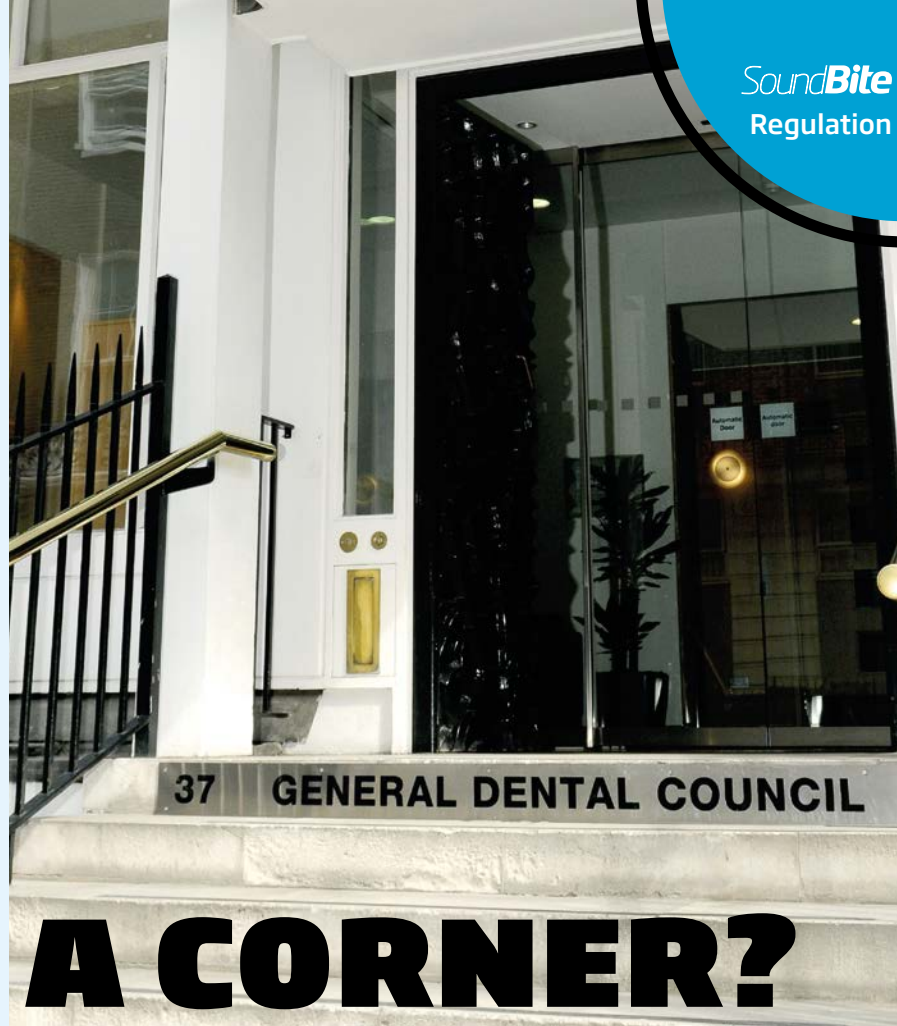
Laura McCormick is a dentist and early practitioner adviser at MDDUS. If you are based in Scotland and have any queries about starting out in practice, email her at lmccormick@mddus.com

Are things starting to look up for the beleaguered dental regulator?

THE General Dental Council has certainly had its woes over the last few years, facing sustained criticism from the British Dental Association along with a Health Select Committee accountability hearing into failings. This included written evidence from the Professional Standards Authority (PSA) describing the organisation as worse than seven of the eight professional regulators it oversees. Not to mention the near unanimous ire of dentists in 2015 over a 54 per cent rise in its annual retention fee.

But are things finally starting to look up?

A new 2016 PSA review published last month found that the GDC is now meeting 21 out of 24 Standards of Good Regulation – up



TURNING A CORNER?

from the 15 met in 2015. Even the BDA has acknowledged some obvious improvement.

Chair Mick Armstrong said: "The General Dental Council has a mountain to climb to cast off its reputation as Britain's least effective and least efficient health regulator.

"This profession acknowledges signs of progress, but the GDC has no grounds for complacency. Today a dentist is still expected to pay more than any other healthcare professional for a regulator that still cannot provide an adequate fitness to practise function."

Here he seems to be referring to the three standards where the regulator is still deemed as wanting – all of which are to do with the way the GDC handles concerns over a registrant's fitness to practise. More specifically the PSA is still not satisfied with the time it takes for the GDC to review fitness to practise complaints and prioritise serious cases for referral to an interim orders panel (to consider whether registration should be suspended or made subject to conditions while an investigation is ongoing). The PSA also noted a continued failure to fully explain the reasons for particular decisions in some fitness to practise cases, as well as concerns over data protection.

But the PSA report does acknowledge the regulator's efforts to improve: "The GDC has made clear in this performance review year that it understands there is considerable work to do for it to resolve the issues that have led to it failing to meet Standards in previous reviews. The GDC has engaged positively with this task and, as a result, has demonstrated that it has made significant progress this year."

A recent change in the way the regulator operates should lead to even further improvement in coming years. In November the GDC began using case examiners to assess complaints against registrants. This means cases will now no longer be referred to an investigating committee for a decision but will instead be considered by a pair of case examiners (one lay and one clinical) who will look at the evidence gathered during an investigation and utilise a suite of outcome options, for example, issuing a warning or taking no further action and closing the case.

Only those cases with a realistic prospect of an impaired fitness to practise finding will be referred for a hearing before one of three practice committees (conduct, performance and health). Essentially case examiners will conduct a "filtering process" but will also have the option at any point in an investigation to refer a serious case to an interim orders committee.

There will also be the option of offering "undertakings" – agreeing steps that need to be taken to bring a registrant up to the required standard. This may include further training or prohibiting certain aspects of treatment until additional training has been completed. Practitioners will be supported and encouraged by the GDC to improve for the duration of the undertakings.

Jonathan Green, Director of Fitness to Practise at the GDC, said: "Introducing case examiners will benefit patients, the public and dental professionals and improve the efficiency of the GDC's fitness to practise process.

"By not having to frequently convene an investigating committee, we will be able to

make decisions quicker than before which benefits patients. We can take action straight away to support the dental professional to improve his practise. This new way of working is also more cost effective, and at the same time relieves unnecessary stress to the dental professional.

"Where a professional demonstrates insight into their failings, remorse and a desire to remediate, we now have a mechanism to be much more proportionate and to agree undertakings in suitable cases without having to hold a full hearing.

"We only want to deploy our investigatory and prosecuting powers where they can make a difference to patient safety and protect public confidence in dental services, which inevitably will be in only the most serious and complex cases."

Jim Killgore is an associate editor of SoundBite

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Study the causes and effects of disease in the challenging specialty of oral and maxillofacial pathology

DIAGNOSIS DETECT

IF YOU have a keen interest in academic study, want to know how and why diseases occur and like microscopy then the specialty of oral and maxillofacial pathology could be for you.

Specialists study the causes and effects of diseases of the mouth and jaws and their associated structures such as the salivary glands, ear, nose and throat. This largely takes the form of microscopic examination of biopsy and excision specimens and issuing a report with advice given on diagnosis and treatment.

It may be one of the smallest dental specialties in the UK (less than 30 oral pathologists currently practise in the UK), but this varied and challenging field has a lot to offer, from diagnostic histopathology to teaching, research and administration.

Entry and training

Those interested in undertaking oral and maxillofacial pathology (OMP) training should have completed one year of dental foundation training and at least one year of dental core

training or equivalent in secondary care in an appropriate related specialty. You should also have the FDS, MFDS or MJDF of the UK surgical royal colleges by examination or an equivalent qualification. Those without FDS, MFDS or MJDF can still access OMP training but will usually be expected to have an appropriate higher degree and/or appropriate experience in OMP or a related discipline.

Satisfactory completion of the histopathology curriculum usually takes five years, according to the Royal College of Pathologists. At least one year is spent in general pathology studying other body systems including the gastrointestinal tract, lungs, soft tissues and haematology, and the remaining four years is spent studying oral and maxillofacial pathology. The award of a certificate of completion of specialist training (CCST) in OMP will be awarded after completion of: the OMP curriculum; a number of workplace-based assessments; the two-part fellowship examination of the Royal College of

Pathologists (FRCPath in oral and maxillofacial pathology); and acquisition of annual review of competence progression (ARCP) outcome six. Relevant research work undertaken after entering the training programme may also count towards the CCST.

Clinicians then apply to be registered as a specialist with the General Dental Council. Despite the overlap between dentistry and medicine, a medical qualification is not required to practise as an oral pathologist.

In addition to training within the specialty there are many other teaching/learning methods trainees can undertake, including supervised experiential learning; online and virtual microscopy; regional/national training courses; discussion with biomedical scientists; and attachment to specialist departments.

The job

According to the British Society for Oral and Maxillofacial Pathology (BSOMP), oral pathologists "like to get things right". They are

TIVES

academically strong, possibly with an interest in research, and have excellent organisational and communication skills.

The Society says: "You probably did well in dental school at pathology, human disease, oral medicine or oral surgery and you enjoy the detective work of making diagnoses.

"You would accept a challenge and be ready to take on responsibility – patients may have major surgery on the basis of your opinion. You would have gained clinical experience in subjects relevant to the work of a pathologist, particularly oral surgery or oral medicine."

Most oral pathologists do not regularly see patients but are often asked to consult on individual patients to assist with diagnostic problems. Specialists are largely based in dental schools, in their associated dental hospitals or acute medical NHS Trust hospitals. Their work is commonly composed of four elements: diagnostic histopathology, teaching, research and administration. The Society describes diagnostic pathology as involving the diagnosis

of disease by microscopic examination of biopsy and excision specimens and examination of resection specimens from cases of head and neck cancer. Depending on work schedules, this can occupy anywhere from half to nearly all of a pathologist's time.

But the role does extend beyond "looking down a microscope". The BSOMP says: "The pathologist also dissects surgical specimens, provides advice on diagnosis and treatment and participates in clinico-pathological case conferences and multidisciplinary team meetings (MDTs). Most oral pathologists are also involved in management and organisation of service laboratories and some are involved in NHS hospital management."

Oral pathologists often take on a teaching role, usually in dental schools, delivering courses in basic science, pathology, microbiology, human disease, oral medicine and pathology, radiology or surgery depending on their experience and skills. These subjects are described as being "among the more academic and complex in the dental course" and teaching students how to understand disease and develop their diagnostic skills can be both a rewarding part of the job and a way of keeping in touch with dentistry.

Many pursuing OMP are interested in

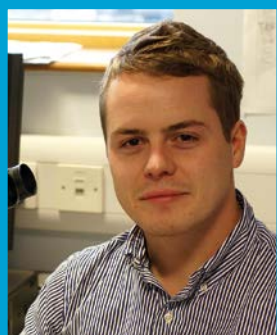
making research a key part of their role. For this you would require a PhD and continuing research interest. Suggested topics might cover oral pathology, pathology in general or a basic science subject. Some also choose to pursue other interests such as education research or forensic odontology, while others follow a management career path. A small number of oral pathologists have full-time NHS contracts but this would likely still involve attachment to a dental school and teaching/research duties.

The specialty offers good opportunities for flexible training and part-time working with paid study leave and opportunities to travel. Its diverse nature promises "considerable job satisfaction" and "you don't have to get up in the middle of the night like surgeons do".

Sources

- The British Society for Oral and Maxillofacial Pathology – www.bsomp.org.uk
- Curriculum for Specialist Training in Oral and Maxillofacial Pathology – tinyurl.com/z4zp86c

Joanne Curran is an associate editor of SoundBite



Q&A

Daniel Brierley, specialist registrar in oral and maxillofacial pathology

• What attracted you to a career in oral and maxillofacial pathology?

Being strong at pathology at dental school I knew my strengths would be best placed in an academic specialty. I liked the idea that my diagnosis could ultimately affect the treatment a patient could receive. This is a big responsibility but also a valuable and rewarding role to have in patient care. I also knew there would be great opportunities to pursue teaching and research so my day would never become boring.

• What do you enjoy most about the specialty?

It is very satisfying to nail a difficult diagnosis. There are hundreds of tumours that can affect the head and neck and sometimes they can look very similar under the microscope. Since I started training, lots of new tumours have been discovered and the ever-evolving list of translocations has kept me on my toes.

• What do you find most challenging?

It never feels good when you accidentally miss something. Luckily, I am still in training so any mistakes I make can be picked up by the overseeing consultant. And that's the thing about pathology – you have to be meticulous in your approach and consider asking for more clinical information or radiology when you need it.

• Have you been surprised by any aspect of the job?

I surprised myself with just how much I enjoy my job. My friends sometimes moan about being in practice or the specialty they have chosen to pursue, but every day I come home and feel grateful to be doing something I am passionate about.

• What personal attributes do you feel are important in oral and maxillofacial pathology?

I think you need to be academically strong and willing to put the hours in with the books. But you also have to have a good "eye". It's difficult to describe what this is, but it's about picking up on the detail while keeping the bigger picture in mind. Although this can be taught to a degree, those with a natural flair for it will find things a lot easier.

• What advice would you give to a student or trainee considering the specialty?

Go and speak with a registrar or consultant and find out more. We are a friendly bunch of people and are always happy to offer advice and support to those who would like to know more about what we do. There are also fantastic dental core training (DCT) jobs in oral and maxillofacial pathology that will give you the exposure to the specialty you need to determine if it's really for you. I did one of these DCT posts and I'm so glad I did.

There are many misconceptions about how indemnity works. MDDUS dental adviser **Claire Renton** sets the record straight

BUSTING INDEMNITY MYTHS

WITH the spookiness of Halloween behind us, we are rapidly on our way to Christmas – my favourite time of year. Even those who don't observe it as a religious holiday will usually enjoy time off work with family, lots of good food, presents and maybe a silly pantomime for good measure.

This got me thinking that much of what we enjoy about this time of year stems not from evidence-based scientific fact but from myths and legends. Well-behaved boys and girls will be rewarded with gifts from Santa; a kiss is promised for those who pass under the mistletoe; and so long as Cinderella doesn't break her curfew then all will be well. And of course everyone knows calories don't count at Christmas... Fantasy is often more appealing than fact but the same should not apply to dental indemnity.

No penalty for advice calls

When it comes to professional indemnity, there seem to be a few fairy tales currently doing the rounds. The first is the ludicrous suggestion that if you call MDDUS for advice then this will lead to higher subscription costs. Some dentists believe that if you call your indemnity provider for any kind of assistance then you will be penalised and your subscriptions will rise based on the number of times you call.

Well, sorry to disappoint but at MDDUS this is simply not true. We positively encourage members to call early for advice as we believe this will help them practise more safely and will help to resolve any issues

before they escalate. Let's take a closer look at how indemnity organisations work. In the simplest of terms, doctors and dentists club together to form a mutual organisation where shared funds are used to compensate patients who have suffered harm as a result of clinical treatment from our members. The mutual fund is also used to advise and support clinicians who are subject to scrutiny from their regulator or patient complaints/claims. At MDDUS we have no shareholders to pay (unlike most insurance providers) and all subscriptions are invested back into the mutual fund to help our members.

So, if you were running this fund which would you rather do? Suggest that members in need of advice call early, and as many times as they like, to prevent problems from escalating, or penalise them for seeking help and leave them to make a potentially costly error? Yup, me too, it's not rocket science. We'd be mad to increase a member's fees because of the number of times they call us. And we don't. We never have. We want members to call at the first hint of anything going wrong. MDDUS has a team of experienced dental advisers on duty from 8am to 6pm during the week plus a 24/7 out-of-hours advice line for emergencies.

Discretion is good

Another common myth scaring dentists just now, and it seems to be particularly aimed at newly qualified colleagues, focuses on the fact that MDDUS indemnity is "discretionary". The story going round is that our ability to operate discretion means that if we get out of bed on the wrong side and we don't want to, then we don't have to provide you with





support or assist you when things go wrong.

Hmmm, that's not true either. The fact is that at MDDUS we appreciate that we're all clinicians and we embrace the ability to carry out our professional duties in our own unique way. We don't want to put unnecessary constraints on our members providing care. Yes, it would be great if patients were always fully informed of every available treatment option and that this was clearly documented in the records and that every root treatment was done under rubber dam – but we know that in reality that's simply not going to happen every time. We can and do use our discretion to help our members in these types of situations. The enormous benefit of being able to use our discretion is that we are not restricted to lists of treatment we can cover you for and are not forced to comply with inflexible terms and conditions such as those found in insurance policies. In many cases we have offered levels of support to our members that would not have been possible with a conventional insurance policy.

We can provide assistance and cover for patient care and what can be defined as the practice of dentistry. It really is very simple. The decision is made by dentists here at MDDUS who recognise that what we do for our patients can't be fully listed in the small print of an insurance policy. We don't ask you to complete an application form confirming how you treat your patients. We don't look for ways to avoid paying out a claim like an insurance company might. For example, if a patient inhales an endo file and you've said in your insurance application form that you always use rubber dam for root treatments, what do you think the shareholder-

paying company is going to do? Pay out or look for ways not to?

Discretionary indemnity really just means that we have the ability to be flexible. We can and do provide cover when the case doesn't quite fit the norm. We don't have to explain ourselves to an external insurance firm. Dental cases are handled by dentists – real, currently registered, proper dentists, who know what it's like to be a dentist and who use their discretion to help and support you.

Unlimited indemnity

There is one final amazing fact that I want to share with you – one which may sound like something out of a fairy tale. If you find yourself called before the General Dental Council, and increasing numbers of good dentists do, we at MDDUS do not put a cap on the fees spent to defend your position. It's hard to believe, I know, but what needs to be spent on your defence team gets spent. An MDDUS basic team for a GDC case consists of a dento-legal adviser (yes one of those real dentists), an experienced clinical negligence solicitor (yes a real registered practising solicitor) and a specialist barrister/advocate (yes a real one). Once you add on others, including an expert witness, it can become very expensive indeed.

However, our job is to protect and defend your position at whatever cost is necessary. Believe me, if you are ever in that situation you would not want to be footing the bill yourself or have expenses capped. Finally, members should be aware that there are no limits on the amount that MDDUS can pay to patients who have been awarded compensation, unlike an insurance company.

So what's the moral in all of this? (There's always a moral). Certainly don't believe the scaremongers and don't be worried into making bad decisions. Please pick up the phone as often as you like and be confident in the flexibility of discretionary indemnity. Oh, one last thing, as this is all about truth and myths, I feel obliged to tell you that Christmas calories do count. Damn.

Claire Renton is a dental adviser at MDDUS

DENTISTS IN

Trainee dentist **Salman Sheikh** tells *SoundBite* about his life-changing work treating refugees in France

DENTAL students rarely have much free time, but London-based Salman Sheikh has been combining his studies with life-changing relief work in the refugee camps of France.

Currently in fourth year at King's College London Dental Institute, the 22-year-old has travelled to Calais with the Refugee Crisis Foundation (RCF) to help qualified dentists deliver emergency care in the notorious 'Jungle' migrant and refugee camp.

His experience there was a far cry from the swish hospitals and private practices he has seen in the UK capital.

Since his first Jungle trip in December 2015 he has made three further visits this year. And while the Calais camp has since been demolished, the RCF plan to expand their work further afield in future.

Salman says the visits have changed him on a personal level.

He says: "You change as the camp changes and grow as a person the more experience you gain. Every visit reaffirmed my motivation to help. You need a lot of emotional strength to hear some of their stories, especially when kids are involved."

It was Salman's first visit, alongside some of his fellow dental students, that had the biggest impact. He will never forget those first impressions of the Jungle which, at its height, was home to as many as 10,000 refugees.

"We didn't know what to expect," he says. "We were briefed, but you just can't prepare for what you're about to see. The disorganisation hits you. I didn't expect that many people to be there. How desperate must they be to travel thousands of miles, with their kids?"

Providing relief

Together with other volunteers, he helped set up a mobile dental clinic in a vacant container, set amongst the mud and cold of the vast camp. A queuing system and triage area was set up outside and a treatment area inside consisting of two mobile dental chairs donated by the Dentaaid charity.

As word of the clinic slowly spread, people

from a diverse range of countries, speaking more than half a dozen different languages, attended. Salman and his fellow students supported qualified dentists, registered to work by the French authorities, in delivering dental care to a steady stream of patients. Many were in severe pain with periapical infections or deep carious teeth.

He says: "The primary objective was to get people out of pain. Many people there had been unable to eat or sleep because of it."

"My role, as a student, was triage and nursing for qualified dentists (non-operative, non-invasive work). We saw a lot of dental infections, abscesses and decay so the most common treatments were carious excavation by hand, GIC restorations and extractions. No treatment was started if it was not urgent and could not be completed in our clinic."

Resourceful

Naturally, the language barrier was a huge challenge, but Urdu-speaking Salman and the dental team were often saved by multilingual refugees and volunteers from other NGOs without whose translation, he admits, "we simply could not have worked in such an extremely diverse camp."

Other challenges included no running water or electricity, meaning no hand pieces or radiographs and limited light as evening fell. Added to this was the constant watchful presence of armed French guards, as well as the various factions (referred to by some as the local "mafia") who exerted control over large parts of the camp.

Lack of supplies didn't stop the resourceful dental team either. A steam steriliser was cobbled together using a hot plate with a pressure cooker on top, an old autoclave was brought back into use, and a makeshift marquee propped up against a shack served as the triage area.

Salman, who volunteered in Rio de Janeiro during a gap year at the age of 18, says: "It was a great experience for me in terms of learning how to work in an emergency dental clinic, running it and seeing how different patients



PHOTOGRAPHS: REFUGEE CRISIS FOUNDATION/SALMAN SHEIKH

are treated in different emergency settings, as opposed to the fancy hospitals and private practices I have seen in London."

Selfless

In addition to his dental work, Salman has also volunteered for various welfare projects run by RCF, distributing tents, blankets, and food parcels to refugees. He advises fellow dental trainees considering volunteering to set their

THE JUNGLE



MAIN PHOTO: Salman examines a Calais patient.
RIGHT: Salman (left) with fellow student Obaid Khalid next to a Banksy mural in Calais

better the team can work."

Despite the scale of the refugee crisis in Europe, Salman believes his efforts are worthwhile but that a long-term solution is needed.

"The teams can take care of people the best way we can, but the real problem is if you don't stop what's causing it [dental decay and other symptoms], how can you change their circumstances? It is circular, people start in need, we then take care of that need, but within a week they might be back in need again. How do we break that cycle?

"I am there thinking 'I've turned up to an earthquake with a dustpan and brush'. One weekend in a month is not enough: we need to increase the care we give and target that care properly. But how do we stop the refugee crisis? That is a question that's bigger than all of us."

When he is not volunteering abroad, or studying for his dental qualification, Salman is busy running a pop-up art gallery in North London, Islamic Imprints Art Gallery, which represents over 25 artists from around the world. He laughs: "I am not all about dentistry!"

But how does Salman manage to balance his challenging BDS course with all his extracurricular activities? He adds: "Balancing it all is difficult, but it keeps life fun. It is good to keep busy, keep things diverse, and do things for a good cause, as long as the dentistry doesn't fall behind. And it hasn't so far, I have made it to my fourth year - let's hope I can make it through the rest!"

- The Refugee Crisis Foundation was founded by pharmacist Kiran Ismail, head of the charity. To find out more email: info@refugeecrisisfoundation.com

Kristin Ballantyne is a freelance writer based in Glasgow



"The primary objective was to get people out of pain. Many couldn't eat or sleep because of it"

personal ambitions aside.

He says: "You can get a hell of a lot out of these trips, so if you are asked to do less glamorous work 'backstage', then do it. It will allow somebody to deliver the care further down the line. I was in the Care4Calais warehouses coordinating food packs and shuttle runs. You have to alternate between that kind of work and the actual delivery of the care itself, so the more selfless you are the

PROBITY

A NIGHT TO FORGET



DAY ONE

Ms D, a final year dental student, is out with friends for drinks in a busy city centre. Just before 11.30pm Ms D and two friends leave to catch the last train home. One of the friends cannot find her ticket and the station guard refuses to let her through the turnstile. An argument breaks out attracting the attention of two police officers. The station guard then accuses the three women of intimidation and racist abuse. All three are arrested and charged.



FOUR MONTHS LATER

Ms D is on course to graduate and has secured a place on a vocational dental practitioner scheme starting in the summer. She has applied to register with the General Dental Council and, as required, declared that she is subject to criminal proceedings. She receives a letter from the GDC to say that her application for registration is on hold pending further information on the outcome of her criminal trial, but the trial is scheduled for two months after Ms D's VDP start date. Ms D replies to the GDC stating that she has pleaded "Not guilty" to the charges and denies making racist remarks. She was only trying to calm down her friend who was angry and inebriated.



ONE MONTH LATER

The GDC responds to the letter refusing to approve Ms D's application on the grounds that she has failed to fulfil the "requirement of good character necessary for registration at this time". MDDUS immediately appeals this decision.



ONE WEEK LATER

An MDDUS lawyer replies to the GDC on Ms D's behalf, arguing that the decision not to register her is disproportionate. The letter makes the point that the charges at this stage are only alleged and that had the incident occurred when Ms D was already a registrant it would be highly unlikely that she would have been removed from the register even after an appropriate GDC investigation of the facts. Enclosed with the letter is proof of the offer to Ms D of vocational training conditional on her registration with the GDC. In addition are eight character references including one from the head of the dental school and another from a VDP trainer.



TWO WEEKS LATER

The GDC replies with a letter recommending that Ms D withdraw her application until after the criminal proceedings against her have been concluded. It advises her to obtain legal and/or professional advice before replying to the letter. Ms D is very upset and contacts MDDUS. She meets with a dental adviser and a lawyer to discuss the case and formulate a plan.

A HEARING is held three months later before a registration appeal committee. The committee considers oral and documentary evidence, including reflective learning logs and CPD undertaken by Ms D since the registrar's decision. One of Ms D's professors attends to testify to her character and excellent academic and clinical ability.

A barrister instructed by MDDUS to represent Ms D submits that the registrar has given insufficient reasons for the decision and failed to take due regard of the fact that Ms D has only been charged with an offence and has denied it from the outset. The criminal allegations remain unproven and are not material in assessing the issue of good character. Guidance from both the

Professional Standards Authority and the GDC on the impact of criminal convictions do not refer to unproven allegations.

Ms D's barrister contends that the decision not to register her has had a punitive effect, resulting in the loss of her vocational training place, which was difficult to obtain given the very limited number of placements available. This has prevented her from practising dentistry and presents the risk of Ms D becoming deskilled.

The registration committee decides that the ongoing criminal proceedings are indeed relevant in judging whether Ms D is of "good character" but that the reasoning applied by the registrar is obscure and inconsistent given the character references submitted in the

case. Taking account of all the evidence on balance the committee decides that the appeal is upheld and the decision of the registrar is quashed.

Ms D is subsequently entered onto the GDC register - and she takes up her vocational training six months later.

Key points

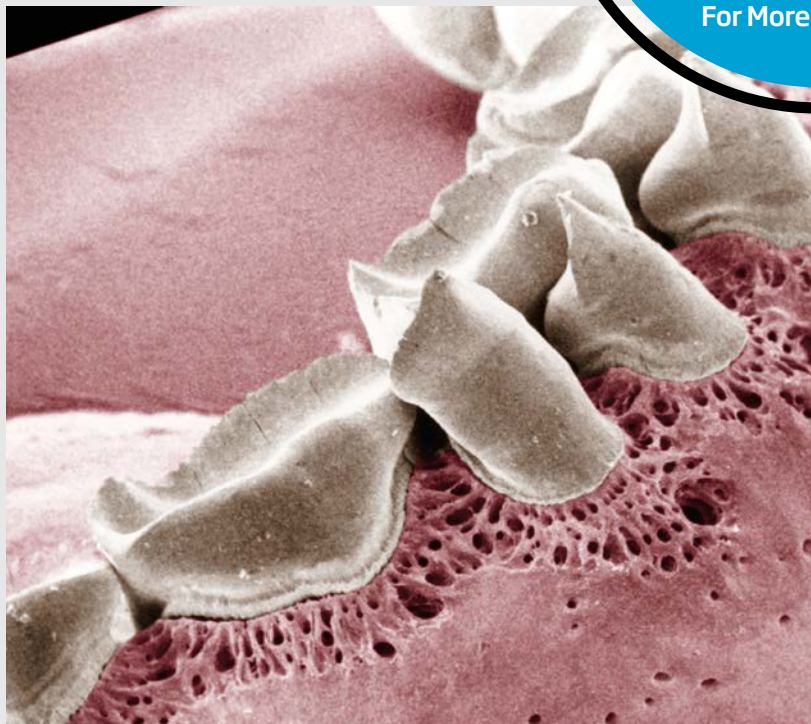
- Contact MDDUS immediately before making any representation to the GDC in regard to criminal charges or a potential complaint.
- Be aware that the GDC holds dentists to a higher standard of behaviour than is expected of the general public.

OUT THERE

CAKE DANGER The office “cake culture” is fuelling obesity and dental problems says the Royal College of Surgeons. They suggest workers should ditch the doughnuts and opt for fruit, nuts or cheese. They say this could help reduce the nearly 65,000 adults who require hospital treatment for tooth decay every year as well as removing temptation from the nation’s dieters. Source: *BBC*

TAKE A BREAK Dentists don’t take enough breaks at work and don’t drink enough. A survey by Dentists’ Provident found less than 40 per cent of dentists don’t stop for lunch while more than 60 per cent take no break at all. Seventy per cent drank only half a litre or less of water daily with more than half admitting they didn’t drink anything else during the day. Dentists’ Provident recommended taking a short break every hour.

GUN CONTROL A 72-year-old Ohio man reportedly accidentally shot himself in the hand after taking a (legally held) loaded pistol to his dental appointment. While under nitrous oxide sedation, it’s believed he reached for his ringing mobile phone but accidentally grabbed his gun instead. Police later advised him to leave his shooter at home next time he was being sedated.



NAME THAT BITE

Stumped? The answer is at the bottom of the page

PHOTO: MOS - BOSTON, VISUALS UNLIMITED / SCIENCE PHOTO LIBRARY MANFRED KAGE / SCIENCE PHOTO LIBRARY

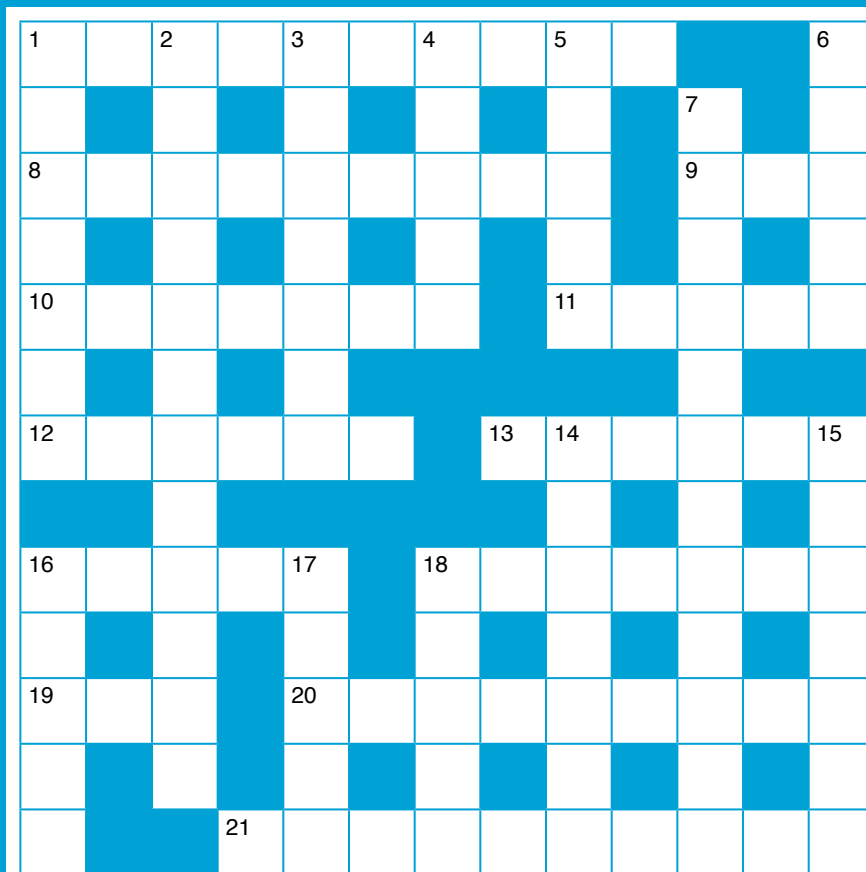
CROSSWORD

ACROSS

1. and 20 across, film musical about sadistic dentist and killer plant (6,4,2,7)
8. Victors (9)
9. Spoken word vocal (3)
10. Perform surgery (7)
11. Japanese cuisine (5)
12. Tooth protection (6)
13. Fee (6)
16. Principal concern of dentistry (5)
18. 1970s Austin car (7)
19. Party of Mandela and Zuma (3)
20. (see 1)
21. Temperance (10)

DOWN

1. Dairy sugar (7)
2. Thomas Cook (6,6)
3. French astronomer and mathematician (7)
4. Nocturnal grunt (5)
5. Band of Gallagher brothers (5)
6. 1970s Ford car (5)
7. Article of nightwear (8,4)
14. Hinged trailing edge (7)
15. Lady of loose morals (7)
16. The sound of a guitar (5)
17. Weapon of mass destruction (1-4)
18. High-ranking Buddhist saint (5)



See answers online at www.mddus.com. Go to the Notice Board page under News.

Questions



MDDUS members can now take advantage of a great new service designed especially for dentists who are just starting out in their career.

If you have questions about what to expect from practice life, need advice on choosing a job or help understanding associate agreements – we can help.

Our new **Early Practitioner Adviser Laura McCormick** is an experienced dentist who will be on hand to offer free educational support and expert insight into working life.



This great new service is provided at no additional charge for MDDUS dental members in Scotland who have graduated within the past five years.

To find out more email Laura on
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www.mddus.com