Sound Bite

ISSUE 02

REDUCE THE FEAR FACTOR

TREATING ANXIOUS PATIENTS

ALSO INSIDE

AN MDDUS PUBLICATION

MDDUS

PHOTO: ROSLYN GAUNT

Welcome to your SoundBite

IN THIS second edition of *SoundBite* there is a diverse mix of articles to help you with the day-to-day management of patients, as well as providing an insight into some other interesting areas of the dental profession.

A continuing challenge in my practice is dealing with anxious patients. I've found one of the most important aspects in effectively treating these patients is good communication. On page 4, I highlight a few tips and tricks on patient management that I've picked up over the past few years to help anxious patients overcome their fears.

MDDUS dento-legal expert Claire Renton looks at some common risk areas for new dentists and offers advice on how to avoid getting into professional difficulty in her article on page 10. She touches on a host of hot topics including sex, drugs and general misconduct.

Protecting vulnerable patients is a professional duty for all dentists and on page 14 the GDC's Jenny Watts explains why clinicians must make it their business to raise concerns about suspected abuse or neglect. More than 5,000 people were diagnosed with oral cancer in the UK last year and on page 12 we discuss the importance of early diagnosis in boosting survival rates.

The focus shifts to the international role played by some dental professionals as Dr John Robson reveals on page 6 how his job as a forensic odontologist has taken him to disaster zones as far afield as Sri Lanka and Bahrain. And for those who are considering a career in orthodontics, our article on page 8 looks at the training required to specialise in this competitive field.

• **Martin Nimmo**
Editor

GDC launches revalidation consultation

THE GDC has launched a 12-week consultation into revalidation – which it says will be implemented in 2014.

Under revalidation, a "standards and evidence framework" will set out the standards dentists must meet under the four domains of clinical, management and leadership, communication and professionalism.

The framework will also set out the evidence which will be acceptable to demonstrate compliance with each standard. The GDC said dentists will gather this evidence over five years, and revalidate at the end of each cycle.

The council is proposing a three-stage process at the end of each cycle:

• Stage 1 – compliance check, which will apply to all dentists
• Stage 2 – remediation phase, which will provide an opportunity to dentists who do not pass Stage 1 to remedy deficiencies
• Stage 3 – in-depth assessment, which will apply to dentists who fail to demonstrate their compliance at the end of the remediation phase.

The consultation sets out proposals for revalidating dentists. It takes into account the findings of an earlier consultation, research and pilots carried out in 2009. The GDC expects further piloting and consultation exercises in 2011 and 2012.

The GDC is very keen to hear from dental trainees and you can respond to the present consultation at **www.gdc-uk.org**. The consultation closes on January 6, 2011.

DENTISTS TRAINED TO SP

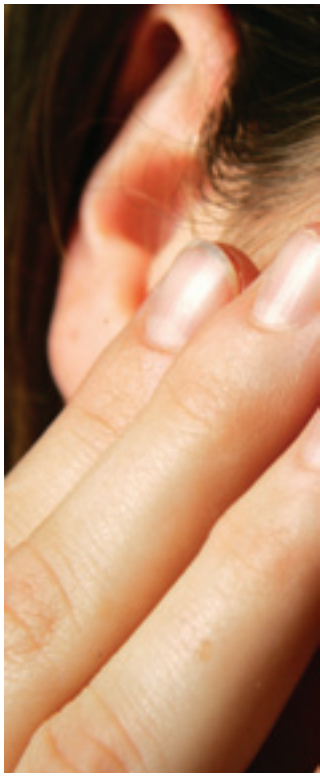
DENTISTS are being shown how to spot the signs of domestic abuse as part of a new pilot scheme.

The initiative is being launched in Ayrshire in the west of Scotland in a joint partnership between Strathclyde Police's Violence Reduction Unit (VRU) and the charity Medics Against Violence (MAV).

Scottish Dental magazine reports that it will initially take the form of a CPD programme and, if successful, will be rolled out nationwide. It may even be included in undergraduate training at Scottish dental schools.

Christine Goodall, oral surgeon at Glasgow Dental Hospital and one of the founders of MAV, told *Scottish Dental*: "Dentists will see women and men who have suffered injuries at the hands of their partners. We know that the majority of victims of domestic violence will suffer injuries to the head and neck, so dentists are actually quite likely to see these people first, as broken teeth will also be a big part of that."

She said that dentists would only be expected to "ask a question and show concern" to patients they suspect are being abused, adding: "If a health professional has expressed concern about them, then they are more likely to go and seek help."



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Major dental standards review by GDC

THE GDC has announced it intends to "go back to square one" in a major review of its *Standards for dental professionals* and is inviting comments and suggestions on how the guidance can be improved. The GDC will also be reconsidering its guidance on *Scope of Practice – who can do what in the dental team*.

Both reviews will take place throughout 2011 with focus groups and events across the UK at which GDC staff hope to hear directly from interested groups and individual dental professionals.

Dental technician David Smith, chair of the Standards Committee, said: "The reviews of both of these documents could result in a radical redesign of the GDC's guidance for registrants and it's therefore extremely important that we hear from everyone who'll be affected and make the right changes.

"This is a significant piece of work for the GDC and one that we anticipate will have a positive impact on dental professionals and therefore on patients."

The GDC said it intends to speak to registrants, patients and other stakeholders and ask them "what level of detail they would find helpful, what they think of the current standards, what works, what doesn't and what's missing."

The new guidance is expected to be published in early 2012.

Comments on *Standards for dental professionals* can be submitted to the GDC now at **standards@gdc-uk.org**. Feedback on the *Scope of Practice* document can be submitted from the end of January via the GDC website (**www.gdc-uk.org**).

Dr title okay says poll

YES

NO

A SURVEY carried out by the BDA has found that four out of five dentists think it is appropriate to use the courtesy title of 'Dr'.

The BDA conducted the survey as part of a discussion hosted on the communities section of its website. The debate attracted high levels of interest, being viewed more than 2,800 times between late July and early September.

The results of the poll have been communicated to the General Dental Council in response to its consultation on *Principles of ethical advertising*, in which it proposes that dentists "should not use the courtesy title 'doctor' (or the abbreviation 'Dr') unless they have a PhD or are a medically qualified and registered doctor".

The draft consultation document further states: "Its use as a courtesy title is potentially misleading to patients and it is important that patients do not assume that you have training or competencies which you do not possess."

Dr Susie Sanderson, Chair of the BDA's Executive Board, said: "This issue has generated unprecedented levels of interest from contributors to the BDA's online communities. Participants have sent a very strong signal about their wish to continue using the title Dr. We have listened to them and will convey the strength of that feeling to the GDC in our response to its consultation on this issue.

"It is clear from the contributions to this forum that, as long as it is made clear that the individual in question is a dentist, patients do not seem to be confused by the use of the title. The practice of referring to dentists in this way is long-established overseas and is also now firmly embedded in the UK."

The GDC expects to publish the final guidance on *Principles of ethical advertising* in early 2011.

OT DOMESTIC ABUSE

MDDUS dental trainee members can apply now for grants worth £1,000 to use in education and training.

Successful applicants must be working in a dental training practice where both the trainee (commencing training in August 2010) and trainer are MDDUS members.

MDDUS recognises that it can be tough financially embarking on a dental career and the grants can be used for any educational activity including attendance at courses, conferences and seminars, practice training and the purchase of text books.

For more details, including full terms and conditions, contact **kwalsh@mddus.com**. The deadline for grant proposals is March 31, 2011.

MDDUS would like to congratulate this year's grant winner – Mr John Perry, a VDP working in Dunoon.

Treating anxious or phobic patients presents a unique challenge to dentists. *SoundBite* editor **Martin Nimmo** offers some advice

REDUCING THE FEAR FACTOR

IT SEEMS never a day goes by without at least one patient reminding you how much they loathe injections, fillings or root canal treatments and bringing up that time the dentist had his knee on their chest to complete an extraction. While I have yet to meet a member of the profession with such remarkable flexibility, it is commonplace to have to manage patients' misconceptions or misgivings about dental treatment.

There are many reasons why such ideas are formed by patients, but often they stem from feelings of fear or anxiety. It is important for any dentist to be aware of the extent of these feelings and to be able to distinguish between a patient who is mildly anxious or one suffering from a more serious and deep-rooted phobia. There are various approaches to dealing with these issues as I have discovered in exploring this topic for *SoundBite* and through my own practice. Finding the right approach for each patient requires gaining an understanding of their fears through good communication skills.

The presentation of anxiety

Identifying an anxious patient is not always easy. Some may be more than happy to recount their fears and previous bad experiences at length, but for others the signs may be more difficult to detect. You might notice that a patient is unusually quiet and unwilling to talk about their concerns, perhaps due to embarrassment. You might notice their hands shaking or sweating or that they look pale. If you suspect a patient is feeling anxious then it is useful to enquire in a non-threatening way if there is anything they would like you to clarify before the examination or treatment begins.

You can also take the opportunity to ease their anxiety during the consent process by giving them a step-by-step account of the different stages of the proposed treatment. As well as reassuring the patient about each stage, it is important to judge how much information a patient wants to know. You must give enough information to ensure valid consent but giving a graphic account of a surgical extraction, for example, is certainly not going to alleviate fears of an already anxious patient and will likely make the ensuing half hour stressful for both parties. It can also be helpful to agree a stop signal with the patient so that they can request a break. This gives the patient a feeling of control over their treatment, so be sure to obey the signal.

Phobia

Some patients who are reluctant to discuss their dental anxiety may already have coping mechanisms in place which means they can normally deal with most aspects of treatment with simple reassurance and empathy. However, for other patients the problem can be more severe.

One indication that a patient is not coping with their anxiety is repeated missed appointments or short-notice cancellations. These patients tend to visit the dentist in pain but don't complete courses of treatment. From personal experience, I have found that by telephoning patients you suspect to be staying away for this reason, you can help identify the anxious from the disorganised. Showing anxious patients that you are concerned about their fears can help establish trust between the dentist and patient and hopefully facilitate successful future treatment. It is far better to take the time to try and ensure these patients attend than face the alternative of them presenting as emergencies when you not only have to deal with their pain, but also their heightened sense of anxiety.

Aggression

From an early stage in undergraduate clinical years, we experience a multitude of patients with odontogenic pain, which can occasionally elicit uncharacteristically aggressive behaviour. Again, this may be due to the anxiety surrounding treatment or possible worries about not achieving anaesthesia. In more extreme cases, a patient may not have slept or eaten for days and it is important to bear this in mind when communicating with them.

By empathising with their situation and again taking the time to reassure these patients, the majority will begin to calm and in turn allow treatment to be undertaken. But it is also important to remember to warn patients whose aggressive behaviour – whether verbal or physical – is escalating that it will simply not be tolerated. You should never put yourself or members of the dental team in a position that threatens your safety.

Treatment planning

Good communication is one of the fundamental principles of alleviating anxiety and by identifying patients' specific fears you can devise a treatment plan that will help build their confidence. Needle phobias, for example, are a common cause of concern to patients. The various approaches to needle desensitisation are covered in the undergraduate curriculum, but the time some of these techniques take to implement in

general practice can be a deterrent for clinicians. It is worth choosing and practising a sequence where you can put the patient at ease in a time-efficient manner.

Factoring in any possible dental anxiety in your treatment planning can also help increase compliance and instil patient trust in your ability to perform procedures relatively painlessly. For example, when undertaking a restorative treatment it is wise to start with short appointments for small restorations in the upper posterior region if possible. This allows almost painless infiltrations, if given slowly following topical anaesthesia, and can build patient confidence to a level where they feel able to embark upon more complex and time-demanding procedures.

It is also vital that you know your clinical limitations and don't attempt treatment beyond your capabilities, especially on anxious patients. A bad experience is likely to compound negative attitudes towards treatment. If you feel that a patient's clinical or behavioural needs are best met in a specialist setting, you should refer the patient appropriately. Prior to referral, a patient should be made aware of the various sedation techniques available to them, which include inhalation sedation, intravenous sedation and general anaesthetic. It is vital that you inform them of the likely sedative effects these induce and also the associated risks and consequences. This enables the patient to attend an assessment clinic with an informed idea of what is realistically possible.

Oral sedation can be prescribed in general practice, but I have personally had limited success with this method. This may have been due to the fact that I was only using it in cases of moderate to severe anxiety, but patients who felt an alleviation of fears attributed it more to pre-operative communication than the actual sedative effect of diazepam. A secondary care setting may also be able to refer a patient to see a clinical psychologist in particularly severe cases.

"Showing anxious patients that you're concerned about their fears can help establish trust"

Something I was not aware of until recently was that some abuse victims can have real difficulty in dealing with dental treatment. This can be due to a number of reasons, including the feelings of vulnerability and loss of control. It is unlikely that you would find this information from any dental, medical or social history you would take as part of a routine exam but it is important to be sensitive to any other signs of abuse or neglect (see page 14 of this issue).

All of this means it is important not to dismiss behaviours which you may find unusual as there may be a deep-seated physiological problem at play. Dealing with anxious patients can often be frustrating, but the satisfaction from helping a patient conquer their fears can be extremely rewarding. Dental anxiety will remain a daily occurrence throughout your working career, and by dedicating time and developing methods to help those in need, you will begin to establish a content and loyal patient base.

Martin Nimmo is an SHO in oral and maxillofacial surgery and is editor of *SoundBite*

DISASTER WAITING

Forensic odontologist **Dr John Robson** knows what it's like to be one phone call away from catastrophe

THERE are surely very few dentists whose jobs require them to keep a bag packed and their vaccinations up to date, ready to dash to Heathrow Airport at three hours' notice – or whose place of work could be anything from a crumbling mortuary with a fuse box hanging off the wall to a gazebo on the edge of an airfield with no running water.

But for forensic odontologist Dr John Robson challenges like these are routine. Dr Robson is part of a small cadre of specialist dentists in the field of disaster victim identification and a call on his mobile could mean a sudden summons to Colombia or the Congo, Sri Lanka or South Africa, to provide expertise in the aftermath of a plane crash, shipwreck or natural catastrophe.

As with the random nature of disasters, so often is the response. Dr Robson explains: "Each situation is unique and you have to be very adaptable. You don't know what you're going to come up against. In one disaster, we had cockroaches running down the mortuary wall. The conditions were dire."

Over the years he has come up against a wide range of extremely challenging situations, among them the Asian tsunami of 2004, where he led a team of international dentists in Sri Lanka and Thailand in the race to identify thousands of victims, and the Bahrain boating disaster of 2006 in which nearly 60 people were drowned after an Arab dhow capsized.

Dentals ignatures

Forensic odontology is nothing like the image that springs to mind when you think of dentistry. But for the CSI generation the word 'forensics' offers something of a clue. "I did a forensic dental course before most people knew what the word forensic meant," says the 65-year-old laughing. "It really boils down to the evaluation and presentation of dental evidence in the interests of justice. This may be in a legal report or actually in court."

Evidence could mean comparing a bite mark on a rape victim's shoulder to the mouth of the attacker or assessing the age of an illegal immigrant via the growth of their third molar. Or it could mean, as with so much of Dr Robson's work, the identification of a body, be it decomposed, fire-damaged, infested or worse.

"It is the law of most countries that every effort should be made to identify the body so that a death certificate can be issued," he says. "It's also important for reasons of inheritance, re-marriage, life insurance purposes and in homicide cases, where if an ID is done early it gives the police an immediate circle of family and friends, who could be among the first suspects."

Teeth are the hardest tissue in the human body and are much more resistant to decay or destruction than other body parts – as are dental inserts such as fillings, dentures, bridges and crowns. Dental surgeries the world over maintain – in effect – an extensive antemortem database for purposes of comparison. For this reason a person's dental status is recognised by Interpol as one of four primary identifiers along with DNA, fingerprints and unique medical appliances such as numbered hip joints and pacemakers.

"Primary identifiers are those which will stand alone with no back-up other than, say, sex and height," says Dr Robson. In the aftermath of the tsunami in Thailand, dentition was the most significant of the four, with many more positive identifications on dental information alone, compared with fingerprints alone and relatively few on DNA alone.

MAIN PHOTOGRAPH: REUTERS

Main picture: the aftermath of the Asian tsunami of 2004. Above: Dr John Robson, left, identifies a victim from that same disaster

Never an easy job

But dental identification is no easy task and often this is as much due to the circumstances in which the work must take place. As Dr Robson explains: "You arrive in the country and the first thing you have to do is liaise with whoever's in charge. It's usually the chief of police or the coroner, but that can be a problem because what we call a coroner they might call a magistrate, or something else. And sometimes the people you think are in charge aren't really in charge at all.

"From there, you have to find out where the bodies are, assuming they're in one place. I once did a job where the bodies were at three different locations: the local hospital, the funeral home and then a hospital in the next town. That makes the investigation much more difficult."

There's also the physical and emotional strain. Working seven days a week on a short deployment ("You're on your feet a lot of the time and you're concentrating") and dealing with makeshift facilities, pressure from concerned relatives and what could be thousands of dead bodies can take its toll. "The sights are pretty horrific and the smells are pretty horrific. And the worst thing that everybody dreads is when a small bag comes in with the body of a child in it."

But there are rewards, says Dr Robson. "It's such a wonderful feeling when you find somebody. You know you're going to return this body to the loved ones, who've been waiting and waiting – especially in something like a natural disaster. Because most people, once they've accepted the death of a loved one, the next thing they want is the body back."

"Any day, a dentist in general practice may have a policeman or a forensic odontologist knocking on their door asking, 'Could I have the records for Mr Smith?'"

Confirming an identity is almost always about comparing postmortem with antemortem data, and Dr Robson is keen to point out that the collection of as much dentally related information as possible – charts, radiographs, toothbrushes ("a wonderful source of DNA"), dentures, extracted teeth, even a bleaching tray – is just as important as the investigations at the scene. "A lot of people and authorities tend to lose sight of this," he says.

It is in this area that all dentists have a part to play through comprehensive and accurate charting and record-keeping. "I've worked in general practice myself so I realise that dentists are under a lot a pressure, but we owe it to the patients, morally and ethically, to do a decent chart," he says. "Any day, a dentist in general practice may have a policeman or a forensic odontologist knocking on their door and asking, 'Could I have the records for Mr Smith?' And by records we mean all the available information, including charts, models, bills, radiographs and clinical photographs. Too much antemortem info is better than too little!"

Forget the glamour

While forensic odontology certainly has more to do with CSI than general practice, Dr Robson is quick to play down any sense that this kind of work is glamorous. Nevertheless he admits that it was an interest in detective fiction and true crime books that led him in 1989 to enrol on a postgraduate course in forensic odontology. Prior to that he had worked in general practice before moving into specialist orthodontics.

After finishing his course, he joined the British Association for Forensic Odontology (BAFO), introduced himself around and expressed an interest in going abroad on jobs. "Four or five months later," he says, "this chap gave me a ring and asked, 'Would you like to go to Colombia tomorrow?' I said I didn't know and he said, 'Well you've got 20 minutes to think about it and ring me back.'"

Since then he's been deployed all over the world, but until his recent retirement the workload was never enough to allow him to give up his practice work. "It isn't really a full-time career. You can't give up general work," he says. "I'm quite high up in the profession and the amount I work is about once a month if I'm lucky."

That he is a past president of BAFO and is currently chairman of the BAFO Disaster Victim Identification (DVI) group is testament to how 'high up' Dr Robson has risen. In this latest role, which comes under the aegis of the Home and Foreign Offices, he has shifted from his usual 'after the fact' investigation work to policymaking and is currently involved in preparations for potential terrorist attacks in the UK.

"We have been asked to make arrangements so that we can man several disaster sites at the same time," he says. "So we are getting together a pool of forensic odontologists who can be available for that. These have to be experienced dentists who have a postgraduate qualification in forensic odontology and are members of BAFO."

But despite his new role, the habits of 25 years are hard to break and he remains committed to attending disaster scenes around the world as and when required. For the foreseeable future, therefore, he will continue to keep a suitcase at the ready and his vaccinations up to date.

For more information contact the British Association for Forensic Odontology at **www.bafo.org.uk.** The University of West Glamorgan runs a postgraduate course in forensic odontology – contact Dr Catherine Adams.

Profile by Adam Campbell, a freelance journalist and regular contributor to MDDUS publications

ON THE RIGHT TRACK

So you want to be an orthodontist? It's a long hard road but perseverance can offer some rich rewards

Orthodontics is the largest of the dental specialties and no wonder. Last year nearly one million people in the UK underwent orthodontic treatment and it's not only children. More adults than ever before are attending orthodontists to improve their smiles.

The specialty can be defined as the branch of dentistry concerned with the growth of the face and the correction and prevention of occlusal abnormalities. Treatment aims to mitigate the effects of occlusal variation on facial appearance and the health and function of the masticatory system.

A dentist with a BDS or BChD and an interest in orthodontics can consider a number of training options. These include attaining some limited additional training to work as a primary care dentist carrying out straightforward orthodontics in a general practice, or undertaking more extensive training to become a specialist working in an orthodontic practice, hospital, university, the armed forces or a community dental service.

Specialist training

In order to be accepted onto an orthodontic training programme as a specialist registrar you will need to gain a broad experience of dentistry either in a hospital, community and/or general dental practice setting. Places are very competitive and therefore you would be advised to spend time post-qualification developing your CV and gaining varied clinical experience during either your vocational training (VT) or general practitioner training (GPT) years.

The MJDF/MFDS/MFD examination is no longer an essential requirement to enter specialist training but the majority of applicants will have this diploma and you would be advised to complete it. In addition, you should try to get one or two articles published in good dental journals, carry out some audit projects and present at meetings. These activities will help when applying for a specialist training post.

You can apply for specialist training at the Universities of Belfast, Birmingham, Bristol, Cardiff, Dundee, Edinburgh, Glasgow, Leeds, Liverpool, Kings College London, Manchester, Newcastle, Sheffield, Queen Marys and Westfield or University College London, Eastman Dental Institute. Applications are made through the local postgraduate deaneries.

The courses take three years (or equivalent part-time) and comprise clinical training and academic study. After three years you will sit the Royal College examination for the Membership in Orthodontics (MOrth/IMOrth) and, if successful, will gain a Certificate of Completion of Specialist Training (CCST). This will allow you to be included on the specialist list and be known as a specialist in orthodontics. Trainees are also required to study for a higher degree, such as the MSc, MClinDent, MDentSci or DDS, during their training.

After qualifying, there are a number of career options open to specialists. You can work in a specialist practice, usually as a performer (previously known as an associate), and eventually a partner or a principal. There is the further option to work under an NHS contract in primary dental care or undertake treatment privately or a combination of both.

Salaries range from £30,000 per annum for an associate orthodontist (a self-employed orthodontist working in a practice owned by someone else) to over £150,000 per annum for those who operate their own private practices. The average income for an orthodontist is just under £90,000.

Other options

Alternatively, you may decide to become a salaried specialist in the community dental service which provides treatment for special care patients. You can also opt for a hospital setting and work towards becoming a consultant orthodontist which involves a further two years training as an FTTA (fixed term training appointment) and sitting the FDS Orth exit fellowship. Finally, there is the option of an academic career which involves at least four years training post-membership in a hospital/university. During this time you

will undertake FTTA training and do a PhD degree and could eventually become a professor of orthodontics.

Orthodontics in primary care dentistry

Not all orthodontic work is carried out by specialists. It is possible for primary care dentists to train for one session per week over three years, as a part-time clinical assistant, in order to be able to carry out straightforward orthodontics for patients in general practice. Such training programmes are mainly intended for dentists working in areas without a specialist orthodontic practice. Course places are limited and you will not hold a specialist qualification at the end of this additional training.

For individuals interested in becoming a primary care dentist with a special interest (DwSI) in orthodontics there is a three year part-time BOS/FGDP(UK) training programme in orthodontics leading to a Diploma in Primary Care Orthodontics RCS(Eng).

More detailed information on training pathways in orthodontics is available from the British Orthodontic Society website **(www.bos.org.uk)**. The BOS is the umbrella organisation for all dentists with special additional training in orthodontic treatment and it offers on-going learning and support for the profession and funds research into new treatments. Useful information about general professional training and orthodontic training can also be found on the Royal College of Surgeons of England website **(www.rcseng.ac.uk)**.

Q&A Hemendra Shah, FTTA in orthodontics at Bristol Dental Hospital and Royal United Hospital, Bath

• What attracted you to a career in orthodontics?
As an undergraduate training at Bristol Dental School, I was exposed to a lot of clinical orthodontics and was very fortunate to be able to treat a number of cases during my fourth and final year. This initially stimulated my interest in this specialty. I undertook my elective, investigating the provision of cleft lip and palate care in Sri Lanka, which further motivated me to go on to specialise in orthodontics. My vocational training practice did a lot of orthodontics in-house, and with encouragement from VT trainers I was fortunate to continue an active interest in the subject during VT.

• What do you enjoy most about the job?
I find my job very rewarding. You meet such a variety of patients working as a hospital orthodontist, and it is extremely satisfying to see the happiness that orthodontic treatment can produce not only in the smile of an individual patient but also in the confidence that brings.

• Are there any downsides?
The current dental contract does not allow for VTs to try their hands in simple orthodontics which I feel is a shame. My vocational training allowed me to build upon the experience I had as an undergraduate dental student and gave me a taster of treating orthodontic patients in the primary care setting.

• What have you found most challenging in your training?
Orthodontic specialty training was an intense three years. The run-up to the MOrth examination was challenging, trying to complete a range of cases with different malocclusions in time for the examination. But this was the same for everyone taking the examination, as orthodontic treatment on average takes two years, and these are the first ever set of patients that you have treated.

• What about the job has most surprised you?
As a hospital orthodontist, I was surprised at the amount of management training that we are required to undertake in preparation for a consultant role.

• What advice would you give to a young dentist considering orthodontics?
Before applying for an orthodontic specialty registrar post, it is worthwhile getting a broad base of experience during dental foundation training. Vocational training will give you an insight into how dentistry is delivered in primary care, and once you have your VT number, you are eligible to provide NHS orthodontic treatment in primary care, if that is the career in orthodontics you wish to pursue. SHO jobs in maxillofacial surgery, paediatric dentistry and restorative dentistry will provide you with invaluable experience in these branches of dentistry, since a proportion of the cases you will treat during your training and beyond will require multidisciplinary care.

Try and get some experience doing orthodontic treatment or visit local orthodontic hospital departments and specialist practitioners to try and get a feel of what is involved in performing the role of an orthodontist, since orthodontic experience is limited during undergraduate training relative to the other dental specialties.

My final piece of advice would be to identify any weaknesses in your CV and use the time during your foundation training to participate in audit, research, teaching and any opportunities to publish articles, for example case reports.

• What is your most memorable experience so far?
Every day produces a memorable experience in orthodontics. A majority of my caseload are multidisciplinary orthognathic and hypodontia treated with a combined team approach. My most memorable experience is the first orthognathic case that I treated. It was a class 3 case that required a bimaxillary osteotomy, and following two years of treatment, it was rewarding to see the dental and facial changes that were achieved, and the happiness that the treatment produced for the patient.

MDDUS dental adviser **Claire Renton** examines some common dento-legal pitfalls that can catch out the unwary trainee

AS A NEWLY qualified dentist starting out on your career, the idea of finding yourself in professional difficulty may seem a distant prospect. But as any dento-legal expert will tell you, it can happen to even the most conscientious practitioner.

The best thing you can do is to start as you mean to go on by maintaining high professional and personal standards. This may not guarantee that you won't sometime find yourself on the receiving end of a complaint to the General Dental Council or some other claim or investigation but it will at least minimise the chances.

When it comes to getting into trouble, the pitfalls generally fall into two distinct categories: actual treatment issues and social or professional issues.

Treatment issues

The golden rule when dealing with patients is: always act in a way that puts the patient first. If you do this then everything else will fall into place. By putting the patient first, you will automatically ensure that your **examination and treatment planning** is correct and that the patient has a clear cost estimate of the treatment.

This will also mean taking special care in writing up **patient records** – recording all treatment provided, the taking of consent, warnings given about oral hygiene, advice about treatment options and positive and negative findings. Write patient notes in ink or ball point and never obliterate any of the record. If you need to amend an entry, put a single line through the relevant part and initial the change. The need for clear, comprehensive clinical notes cannot be overstated. If you ever find yourself in court in relation to a dispute over treatment provided, a set of accurate and complete dental notes could be crucial in mounting a successful defence.

Putting the patient first should also prompt you to **stay up-to-date** with new techniques and materials. The GDC advises all dental professionals to be aware of their compulsory continuing professional development start date, how many hours they are required to do and to plan and record CPD activities accordingly.

You should also ensure that patients have given their **consent** to treatment. To do this, you must make sure the patient has enough information to make a decision, that they have made the decision voluntarily and that they have the ability to make an informed decision. You can ask someone else to get consent for you but you will still be responsible for making sure – before you start any treatment – that the patient has been given enough time and information to make an informed decision and has given their consent to the procedure or investigation.

And finally, you should respect their **confidentiality** and only use patient information for the purposes for which it was given. In general, confidential patient information should not be disclosed without their consent. In exceptional circumstances you might be able to justify disclosing confidential information without consent if it is in the public interest or the patient's interest. Remember that the duty of confidentiality applies to all information about the patient which you learn in your professional role. If it is necessary to release patient information then get the patient's consent to do so wherever possible; make sure that you only release the minimum information necessary for the purpose and be prepared to justify your decisions and any action you take.

As we all know, not all treatment works exactly as planned. We are working on human beings, not phantom heads and occasionally our well thought-out and executed treatment fails. So how should you respond? Well, the dentist who is putting the patient first would explain to the patient clearly what has happened. Apologise if necessary and, above all, do all you can to make it right. That could mean refunding the cost of the treatment, redoing it where possible, or referring the patient for a second opinion quickly.

If things all go pear-shaped and a dentist is brought before the GDC facing a conduct or performance hearing, the case often boils down to the simple question: did the dentist put the patient first? Those dentists who can show that they acted in the best interests of the

patient as opposed to profit or convenience will fare better.

All fairly straight forward so far. So what are the slightly more scandalous things that can land a dentist in trouble?

"A healthcare professional displaying sexualised behaviour towards a patient may be committing a criminal act"

Drugs and Alcohol

Drugs are a definite "no-no". Sorry, but there's no defence with this one. Alcohol is more socially acceptable and while most people will accept that dentists, like many adults, may enjoy the odd glass or three, be careful how you behave when having a drink. You are still a dentist even on your time off and will be judged by what is considered appropriate or professional behaviour. If the council receives a complaint against you and it is decided your fitness to practise is impaired because of inappropriate or unprofessional conduct, your registration could be suspended – or worse. It is also worth considering the risks of treating patients the morning after you have been drinking alcohol, when your clinical skills may not be as sharp as they should be.

The GDC is told by the police if a registrant has been convicted of a crime or cautioned by the police in the UK. They can also consider convictions and cautions imposed abroad which, if committed in England and Wales, would constitute a criminal offence. The conviction doesn't have to be related to your profession or practice to be considered, and even incidents that happened when you weren't registered can affect your registration. If you are caught driving under the influence of drink or drugs, for instance, it won't just be your driving licence at risk. In the most serious cases, you could be struck off and banned from practice.

Sex

I thought that would get your attention! We should all know that inappropriate relationships with patients must be avoided. GDC guidance *Standards for Dental Professionals* makes it clear by advising dentists to: "Maintain appropriate boundaries in the relationships you have with patients. Do not abuse those relationships." Healthcare regulator CHRE spells out the risks in greater detail, warning: "The healthcare professional/patient relationship depends on confidence and trust. A healthcare professional who displays sexualised behaviour towards a patient breaches that trust, acts unprofessionally and may, additionally, be committing a criminal act."

When it comes to relationships with work colleagues, be very cautious.

Recent cases at the GDC have heard intimate details of affairs between co-workers with allegations flying of unprofessional behaviour and potential patient harm. It's impractical to suggest that staff should never date each other, but it should not be encouraged as it opens up many risk areas.

If you decide to pursue a relationship with a colleague, then make sure personal and professional relationships are kept completely separate. You should not be working together in the surgery so if you are dating one of the nurses, for example, ask to work chair-side with another nurse. If you are the boss and you are seeing a staff member, take extra care as such a relationship could lead to accusations of bullying, harassment or abuse of power. You must not favour the person you are involved with over other employees and equally, it would be wrong to discriminate against a colleague should your personal relationship sour.

Most importantly, you must not use your position in the practice to engage in inappropriate or unwelcome behaviour with a colleague. It's important to understand how your perception of the situation can be totally different to that held by the object of your desire – especially if they do not share your feelings.

As a friend of mine once said, the best advice here is if you begin an affair with someone at work, just be sure it never ends.

For more advice on any of these issues, contact MDDUS, or for more information read the GDC guidance *Standards for Dental Professionals* at **www.gdc-uk.org**.

Claire Renton is a dento-legal adviser at MDDUS

WATCH

Early diagnosis in mouth cancer can enhance chances of survival by up to 90 per cent and dentists have a vital role in reducing mortality

NO ONE tends to think of having regular dental checkups as a matter of life and death. But for some 5,300 people in the UK each year this could very well be the case.

This was the number of UK patients diagnosed last year with oral cancer according to statistics compiled by the British Dental Health Foundation (BDHF). Mouth cancer is estimated to kill one person every five hours, and less than half of those diagnosed with the disease survive beyond five years of diagnosis.

November was Mouth Cancer Action Month and the BDHF – as part of an ongoing campaign – has been very active in raising awareness of the disease among the public and the healthcare community. Part of that campaign has been to ensure that all dentists carry out oral screenings on each of their patients at least annually or on every dental visit.

Dr Nigel Carter Chief Executive of the BDHF says:

"We need to continue to take action to raise awareness of mouth cancer and ensure that thorough oral examinations stay a priority. We are urging dental and medical practices, pharmacies, health centres and oral health educators to help in raising awareness of the early symptoms and the main risk factors to the public.

"The chance of survival can be increased to 90 per cent through early detection. Without early detection the survival rate plummets down to 50 per cent, and this has not improved over the last four decades."

Know the signs

Many different types of cancerous tumours can arise in the mouth but around 90 per cent are squamous cell carcinomas, according to the USA-based Oral Cancer Foundation. Common areas for mouth cancer to develop include the tongue and the floor of the mouth, or the sulcus between the lip or cheek and the gingival covering of the lower jaw in individuals using chewing tobacco.

Oral cancer is particularly dangerous because in its early stages it can often go unnoticed by the patient as there may be little or no pain or physical changes. It is often only discovered after the cancer has metastasised, most likely to the lymph nodes of the neck. The prognosis at this stage will be significantly worse than for cancers localised to the intra-oral area. Late diagnosis may also allow the primary tumour time to invade deep into local structures.

Warning signs for mouth cancer include:

- Ulcers which do not heal within 3 weeks – a small indurated ulcer which looks like a common canker sore
- Red and white patches in the mouth
- Unusual lumps or swellings in the mouth
- Difficulty chewing or swallowing food
- New persistent pain.

But it can be difficult to judge which signs necessitate concern. Many routine conditions can mimic the appearance of pre-cancerous changes or early cancers of the soft tissues. One study cited by the Oral Cancer Foundation found that an average dentist can see 3-5 patients a day who exhibit soft tissue abnormalities, most of them benign in nature. Apthous ulcers, herpes simplex, herpes labialis, cheek trauma and sore spots from poorly fitting dentures can all share similarities with dangerous lesions.

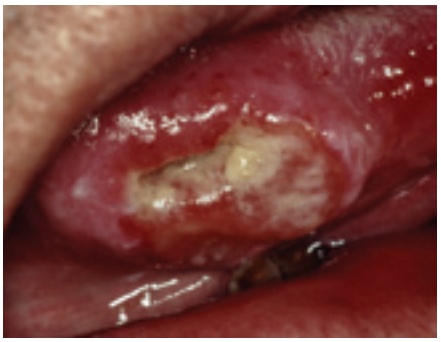
Risk factors

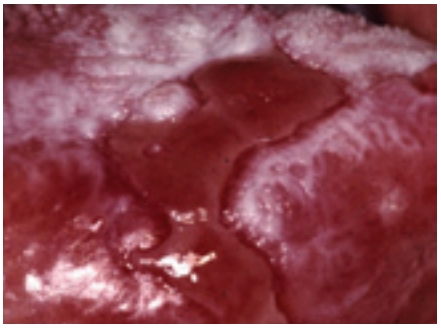
Cancer Research UK advises a "high level of suspicion" when assessing patients for mouth cancer symptoms, especially when patients fall within certain known risk categories. These include:

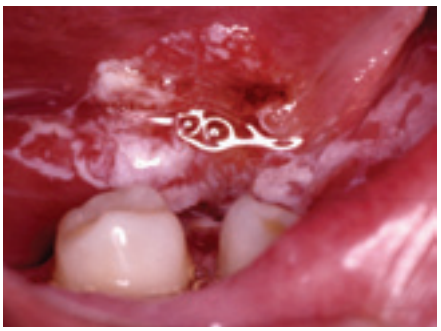
- Smoking – still considered to be the leading cause of mouth cancer in the UK.
- Alcohol consumption – drinking to excess can increase mouth cancer risks by four times. Those who smoke and drink to excess are up to 30 times more likely to develop the disease.
- Poor diet – around a third of cases are thought to be linked to an unhealthy diet. It is recommended that people eat a healthy balanced diet including five portions of fruit and vegetables each day.
- Chewing tobacco, paan, guthka and areca nut.

ING BRIEF

From top: carcinoma on the lateral border of the tongue; ulcerative lichen planus; isolated non-homogeneous white patch







• HPV – The human papilloma virus, transmitted via oral sex, has recently been identified as a risk factor, particularly in younger people with no other apparent risk factors. Experts suggest it may rival tobacco and alcohol as a key risk factor within 10 years. People with multiple sexual partners are more at risk.

Age is also an important factor to consider with 87 per cent of cases in the UK occurring in people aged 50 or over. Sex contributes to risk but increasingly less so today. Dr Nigel Carter says: "Fifty years ago mouth cancer was five times more common in men than women. Now it is only twice as common."

Referral guidelines

Both Cancer Research UK and the National Institute for Clinical Excellence provide guidance for dentists on when to refer patients with oral symptoms suggestive of cancer.

NICE states that in general any patient with "persistent symptoms or signs related to the oral cavity in whom a definitive diagnosis of a benign lesion cannot be made should be referred or followed up until the symptoms and signs disappear. If the symptoms and signs have not disappeared after 6 weeks, an urgent referral should be made".

Any patient presenting with unexplained red and white patches (including suspected lichen planus) of the oral mucosa that are painful or swollen or bleeding should be referred urgently but if lichen planus is confirmed the patient can be monitored for oral cancer as part of routine dental examination. NICE further recommends that: "In patients with unexplained ulceration of the oral mucosa or mass persisting for more than 3 weeks, an urgent referral should be made."

Following accepted clinical guidelines and documenting this adherence will both help ensure the welfare of your patients and protect your professional standing should a missed or delayed diagnosis lead to a claim for damages.

MDDUS Head of Dental Division Mr Aubrey Craig says:

"Dentists have a duty of care to their patients to carry out a regular screening of the oral mucosa. Any abnormalities should be recorded, the patient informed and onward referral made for appropriate investigation. Practitioners may find a small gauze square useful in manipulating the patient's tongue to assist with visualisation of the posterior areas. Dentists are uniquely placed to diagnose problems as they see their patients on a regular basis."

Promoting awareness

To the list of known risk factors for oral cancer one might also add ignorance. Dr Nigel Carter says: "While awareness of cancer in general has increased rapidly in recent years, we are still faced with the problem of a lack of awareness of mouth cancer. Around one in four people have never heard of the condition according to our surveys and less than half can name the risk factors correctly."

The BDHF suggest various ways that dentists can help raise awareness. Most important is to discuss the risk factors and symptoms with every patient and carry out a full mouth examination. Other ideas that practices might consider include creating a display with posters and leaflets or offering an afternoon of free mouth cancer examinations to patients and local community groups. Ensure also that your staff, including receptionists, nurses and hygienists, are fully aware of the risk factors and able to sensibly advise patients worried about oral symptoms.

Some timely advice could make all the difference.

Useful resources

• British Dental Health Foundation – **www.dentalhealth.org**
• Cancer Research UK – Mouth cancer referral guidelines for dentists at **http://bit.ly/avooxu**
• NICE: Referral for suspected cancer – **www.nice.org.uk/guidance/CG27**
• Oral Cancer Foundation – **http://oralcancerfoundation.org**

Jim Killgore is publications editor at MDDUS

PROTECTING THE VULNERABLE

Jenny Watts of the GDC explains why dentists must make it their business to raise concerns about suspected abuse or neglect

STORIES about the abuse of children and vulnerable adults are distressing for anyone to read, particularly when it appears no-one spotted or stopped the abuse before serious harm was caused. For health professionals there is the added concern of whether they should be the ones ringing alarm bells. Is there a patient they've seen who is suffering? Should they report their suspicions or are they over-reacting? What will happen if they do nothing or indeed if they do act and their fears prove unfounded?

The General Dental Council (GDC) expects all registrants to be aware of the procedures involved in raising concerns about the possible abuse or neglect of children and vulnerable adults. In our *Standards for dental professionals* we say: "Find out about local procedures for child protection. Make sure you follow these procedures if you suspect that a child might be at risk because of abuse or neglect."

This guidance applies equally to vulnerable adults. The GDC considers that the term 'vulnerable adults' means "a person above the age of 18 years who is or may be in need of community care services (including healthcare) by reason of mental or other disability, age or illness; and who is unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation" (Taken from *See Who decides* – 1997 Consultation paper issued by the Lord Chancellor's Department).

Some of you may be more likely than others to come across these issues during your career. Perhaps you will choose to become a specialist in paediatric dentistry or special care dentistry. The latter of which is concerned with the improvement of oral health in individuals and groups in society who have a physical, sensory, intellectual, mental, medical, emotional or social impairment or disability or, more often, a combination of these factors.

How to identify and raise concerns

As a dental professional, you have a responsibility to raise any concerns you may have about the possible abuse or neglect of children or vulnerable adults. You may observe and identify injuries to the head, eyes, ears, neck, face, mouth and teeth, as well as other welfare concerns. Bruising, burns, bite marks and eye injuries are the types of signs that could suggest a concern should be raised.

It's not easy to know whether you are right or wrong to be concerned. The web-based resource *Child Protection and the Dental Team* (www.cpdt.org.uk) was specifically developed as an educational online resource to help you make decisions and guide you through the process should you decide to take action. It suggests you look out for these sorts of issues:

- Has there been a delay in seeking dental advice for which there is no satisfactory explanation?
- When you examined the child, were there any injuries which cannot be explained?

Allow the child to talk and volunteer information – don't ask leading questions. It is your responsibility to know who to contact for further advice and how to refer to an appropriate authority. If you are unsure of the local procedures in your area, you have a duty to find out what they are, whether you work for the NHS or in private practice. You should also contact your defence organisation or professional association for advice. Remember that if you make a professional judgement and decide not to share your concern with the appropriate authority, you must be able to justify how you came to this decision.

PVG Scheme and helpful resources

One of the most significant changes in this area in Scotland is the Protecting Vulnerable Groups Scheme (PVG Scheme). This is due to be introduced in February 2011 and is replacing the current disclosure arrangements for people who work with vulnerable groups.

The legislation behind this (the Protection of Vulnerable Groups (Scotland) Act 2007) is Scotland's response to the Bichard Inquiry report which looked into whether the murders of Soham schoolgirls Holly Wells and Jessica Chapman could have been prevented. If you haven't already, you should find out how this is going to affect you and your colleagues. Find out more by logging on to **www.scotland.gov.uk.**

There are many other organisations and resources you can refer to for help. The 24-hour Child Protection Line will give you access to local child protection services in Scotland on **0800 022 3222** or you can go to **www.infoscotland.com/childprotection** where you will also find information about links in your area.

You could also turn to charities for advice. In 2008/09, the NSPCC Helpline (**0808 800 5000**) spoke to nearly 30,000 adults worried about a child. Over 11,000 of those calls resulted in a referral to the police or children's services to take some form of protective action.

Jenny Watts is Standards Manager at the General Dental Council

OUT THERE

BIG BRUSH In a triumph for dental innovation, Shanghai Zoo have constructed a four-foot long toothbrush to clean their wild hippos' teeth. Visitors can watch while staff dislodge big chunks of fruit and veg that have clogged up the beasts' canines. The new approach has also been adopted by London Zoo where staff have swapped their normal brooms for the specialist equipment.

GOLDEN GOBS **Slightly unsettling news from a UK gold buying website which has revealed more than 500 people have flogged their gold teeth and fillings for cash. The firm Postgoldforcash.com blame a downturn in demand for once fashionable gold "fronts" - "worn by rap and hip hop stars and their fans throughout the decades" - and rising gold prices for the increasing sales.**

THE DENTURES THAT SAVED BRITAIN Winston Churchill had dentures specially designed to retain his distinctive lisp in wartime broadcasts – or so claimed Derek Cudlipp, the dental technician who made them. He also used to flick them out his mouth when angry and throw them across the room. Said dentures have just been sold at auction for £15,200.

JUMBO BURGER WARNING **Add another to the list of health risks attributed to fast food chains. Dentists in Taiwan are urging restaurants to reduce the width of super-sized burgers to below three inches to prevent painful jaw injuries. Some giant burger fans have reported sore jaws or difficulties in opening their mouths. The human mouth is designed to gape over objects measuring only up to one-and-a-half inches according to Professor Hsu Ming-lun of National Yang-Ming University.**

NAME THAT BITE

Stumped? The answer is at the bottom of the page

PHOTOGRAPH: LARRY DUNSTAN/SCIENCE PHOTO LIBRARY

MediaBite
Must-have dental apps

PHOTOGRAPH: DENTALDEMOSUITE.COM

THEY say there's an app for everything. These days anyone with the right kind of smartphone or tablet computer – and the know-how – can access applications offering everything from an onscreen medical x-ray, a programme tracking your alcohol intake and a set of virtual bongo drums that can be played by banging on your screen.

And never ones to be left out of the technological revolution, the dental industry has created a diverse range of weird and wonderful apps for sale.

So what exactly is on offer for trainee dentists? At the top of the range is the DDS GP app, pictured left, which costs a mere $399 to download. It boasts the latest technology to help "increase case acceptance through better patient understanding of their dental health." It includes more than 160 diagnoses and procedures and some fancy colour images illustrating decay, cracks and periodontal disease. The programme conveniently pledges not to scare patients by not "showing blood, needles or drills."

If that sounds too much, then why not start small with the Teeth Whitening app for $0.99? It displays a handy list of whitening tips and helpfully explains: "Everyone wants to get a best teeth whitener to make teeth cleaner... To achieve it they consume lots of money on teeth whitening products."

Another bargain is the Tooth Brushing Motivator which, for just $2.99, could help "guide and motivate" those reluctant patients. An image of a mouth full of teeth appears, with each tooth changing colour as you brush. The encouraging promotional blurb promises: "It is fun and not as strange as it sounds."

Treating those nervous patients could become a breeze if you download the Overcome Fear of The Dentist app. Created by Darren Marks, "one of the UK's leading hypnotherapists", the app claims to "help you begin to reprogram your mind to react in an appropriate way when you visit the dentist." All that for $4.99. And for those who find prescribing a challenge, there's The Little Dental Drug Booklet, which bills itself as "everyone's favourite pocket prescription guide". For $9.99 the app offers a quick reference resource for medications most commonly used in dental practice. Who needs seven years of training when you have all these?

***Joanne Curran is associate editor of* SoundBite**

NAME THAT BITE: *teeth of a pig*

MDDUS

MDDUS are once again offering two £1,000 awards to successful applicants from dental training practices where both the trainee (commencing training in August 2010) and trainer are MDDUS members.

We recognise that financial constraints can often be a barrier for dental trainees interested in pursuing some of the varied educational opportunities available. MDDUS grants can be used for any form of educational training including attendance at courses, conferences and seminars, practice training and the purchase of text books.

Please note that only proposals which reach the MDDUS by the deadline of March 31, 2011 will be considered.

For more details, including full terms and conditions, contact kwalsh@mddus.com