Sound Bite

ISSUE 04

YOU'VE COME A LONG WAY

THE BDA MUSEUM GIVES A FASCINATING GLIMPSE INTO THE PAST

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AN MDDUS PUBLICATION

PHOTO: ROSLYN GAUNT

Welcome to your SoundBite

A CRUCIAL element of being a dental professional is respecting our patients and helping them to make informed decisions about their care. And while the topic of consent is one that's hammered home in undergraduate courses, in practice it can present a challenge. My article on page 4 highlights some basic principles of consent and offers advice to new dentists to help you stay on the right track.

There are numerous treatments and techniques available to complement the practice of 'traditional' dentistry, including homeopathic dental treatments. But opinion is divided on their effectiveness and on page 5 ethics lecturer David Shaw looks at the arguments on both sides of the issue. The use of hypnotherapy in dentistry is another increasingly popular option and on page 12 dentist Mike Gow talks Jedi mind-tricks as he reveals some of the useful techniques that can be applied in everyday practice. The use of positive language and understanding language patterns plays an integral part in hypnotherapy treatment.

In our careers article on page 8, Simon Wright looks at what it takes to get involved in the increasingly popular field of implant dentistry while on page 10 MDDUS dental adviser Claire Renton highlights some important issues for dentists interested in starting their own practice. Meanwhile, the case study on page 14 follows a case of clinical negligence involving the missed diagnosis of a dental abscess.

And we take a step back in time on page 6 where Jason Finch of the BDA Museum highlights some of the weird and wonderful items on display that tell the story of the history of dentistry, including a clockwork drill and a 19th century phantom head complete with real teeth.

- **Martin Nimmo**
  Editor

COVER PHOTO: BDA MUSEUM

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CALLING ALL dental students - 'like' our new MDDUS Student Facebook page and you'll be entered into our FREE prize draw to win £50 of iTunes vouchers. Visit our page at **www.facebook.com/mddus.student** or search Facebook for 'mddus student'.

NO INCREASE IN GDC RETENTION FEE

REGISTRATION fees for dentists and DCPs will not rise in 2012 following a decision by the GDC.

This means dentists will pay £576 by 31 December 2011 and dental care professionals £120 by 31 July 2012. Full details of the GDC's annual retention fee and budget can be found at **tinyurl.com/5v7oqbg**.

MORE DENTISTS SUSPENDED, BUT FOR SHORTER PERIODS

THE NUMBER of doctors and dentists in England excluded or suspended from work has increased over the past five years, but the length of bans imposed has decreased, new figures show.

A report from the National Clinical Assessment Service (NCAS) shows that last year there were 216 new "episodes" of exclusion of hospital and community (H&C) doctors (134 cases) and suspension of general practitioners (82 cases), up from 140 in 2005/2006.

Last year three H&C dentists were excluded and 12 general dental practitioners (GDPs) were suspended compared to four H&C dentists and one GDP in 2005/2006.

At the end of March 2011, 47 H&C doctors, 47 GPs, one H&C dentist and six GDPs were excluded or suspended from work. H&C doctors and dentists were excluded for an average of 21 weeks, down from 23 weeks in 2009/2010, while GPs were suspended for an average of 35 weeks, compared to 44 weeks the previous year.

Figures for GDPs are only available for the last two years and are less representative but the report suggests the risk of suspension for GDPs is low. The average suspension period was 38 weeks at the end of March 2011 compared to 19 the year before and 39 in 2009.

The NCAS figures relate to NHS exclusions and suspensions and not to those imposed by the General Medical Council or General Dental Council. The term suspension applies in general practice while the term exclusion applies to H&C practitioners but both mean the practitioner is removed from clinical work.

Senior NCAS adviser Claire McLaughlan said that overall the number of working weeks lost because of suspensions or exclusions of doctors and dentists fell by 14 per cent from 2009/2010, which could generate a saving of more than £3million for the NHS.

WHISTLEBLOWERS GIVEN NEW PROTECTION

NHS STAFF who blow the whistle will be given greater protection, the health secretary Andrew Lansley has announced.

Changes are being made to the NHS Constitution to protect all health service workers who raise concerns. But the changes will also make it clear that NHS employees have a duty to "report bad practice or any mistreatment of patients receiving care from the health service."

The Department of Health (DoH) said the amendments will be enshrined in the NHS Constitution and associated guidelines in early 2012 in the hope of encouraging more staff to come forward with concerns.

NEW DENTAL CONTRACT 'PRIORITISES CHILDREN'S ORAL HEALTH'

A NEW dental contract that aims to improve children's oral health is being piloted in England.

Dentists taking part in the trial will be paid for the number of patients they care for and the health results, rather than the number of courses of treatment performed. The old contract was criticised for encouraging clinicians to concentrate on activity with no specific rewards for high quality care.

The government hopes to introduce a new contract across the country that will improve the oral health of NHS patients – particularly children. The trials are taking place at 68 practices and will look at ways of increasing patient access and promoting preventative dental treatments like fluoride varnish.

The launch of the pilots has been welcomed by the British Dental Association who described the current contract, introduced in 2006, as "bad for patients".

GDC ACTS TO SPEED UP CASE HANDLING

AN INCREASE in the number of decision meetings and hearings to clear a backlog of cases and an improved process to fast track the most serious ones are among a raft of changes announced by the GDC to improve the handling of complaints against dental professionals.

The GDC said the changes mark the first phase of a complete overhaul of its complaints handling (fitness to practise) processes.

Other measures include the provision of clinical advice at the outset, where appropriate, in order to complement the early diagnosis process and ensure cases are handled appropriately. The GDC will also introduce a rigorous quality assurance process for all stages of the complaints handling process and the introduction in 2011 of a new case management database to assist workflow and provide management information.

Additional measures aimed at further improving timeliness and proportionality in fitness to practise processes will require legislative change and the GDC is working with the Department of Health to effect these. A full consultation on the nature of these changes is planned for early 2012.

Director of Regulation at the GDC, Neil Marshall, said: "We are confident that the changes we are putting in place will help us to assure the public and the dental profession that we are performing our public protection duties as efficiently and effectively as we possibly can."

APPLY FOR £1,000 TRAINING GRANT

MDDUS DENTAL trainee members can apply now for a £1,000 grant to use in education and training.

Successful applicants must be working in a dental training practice where both the trainee (commencing training in August 2011) 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 January 31, 2012.

MDDUS would like to congratulate this year's grant winner – Amy Louise Harper, a VDP at Loanhead Dental Practice in Midlothian.

NEW YOUNG DENTIST GROUP

A NEW group has been set up to represent young dentists in Scotland.

William Keys and Paul Mooney established the BDA West of Scotland Young Dentist Group and plan to hold regular meetings, social events and training opportunities. Practitioners under 35, those within 12 years of graduation and dental students are invited to join the group. Applications are also open for positions including chairperson, secretary and social conveners until December 11, 2011.

For more information email **youngdentist@hotmail.co.uk**

MAKING AN INFORMED DECISION

AS DENTAL professionals, we strive to respect patients' dignity and choices in our day-to-day work. This principle is central to the notion of informed consent. Although a topic hammered home in undergraduate courses, consent can present a challenge in practice. And external factors like treatment cost, time constraints and provider regulations often only compound the complexity of this essential process.

The General Dental Council's *Principles of Patient Consent* makes it clear that to obtain valid consent a clinician must ensure they are suitably trained and qualified and know sufficient detail about the intervention, that they understand the risks and follow the principles set out in the guidance. Although most treatments are routine procedures for dentists, following this guidance is not always straightforward. This can be particularly evident in a hospital setting where you may be consenting for a complex procedure with greater associated risks that you are unfamiliar with. In these cases, a senior member of staff can help you perform the relevant consent procedure.

The GDC explains that "for consent to be valid, the patient must have received enough information to make the decision." Although the risks and benefits of treatments are discussed at a new patient examination and treatment plan visit, it is important to remember that informed consent is a journey, and not a one-off discussion.

If, for example, a patient needs multiple treatments, they can easily become confused at the vast array of benefits, drawbacks and costs to consider. Even if a patient reaches a decision during the appointment, it is worth having practice literature for them to read after their consultation. Booklets and flyers explaining a wide variety of treatments are available commercially, but there is nothing to stop you creating your own. Patients retain very little of the information given to them by healthcare professionals and are sometimes embarrassed to ask for further explanations.

Be sure to note down in the patient's record which literature you give them as this can help defend against any claims made by patients who allege they were not told of the side-effects or risks of a procedure. Problems can arise if a patient rushes into a decision and later regrets having treatment, or equally if a patient takes a particularly long time to decide and later regrets consenting. If you are in any doubt that a patient cannot grasp the implications of proposed treatment, then you should seek advice before proceeding.

"Informed consent is a journey and not a one-off discussion"

The ease with which you obtain informed consent will vary according to the patient. Indecisive patients can be a challenge and while it may be tempting to take the 'Well, if it were my tooth....' approach in a bid to push them towards a specific treatment, as a clinician you must resist this urge. Although it is perfectly justifiable to explain which treatment option you feel is best and why, for consent to be valid it must be given voluntarily. Inevitably, indecision is a frustration during a busy working day, but where appropriate a patient should be supplied with the appropriate information and given time to consider the options before consenting. Remember, patients have a right to refuse to give their consent for an investigation/treatment and you should be prepared to respect this decision.

Consent can be given verbally or in written form. Written consent should be obtained for complex treatments and for treatments involving sedation or clinical photography. Having a list of the benefits and common complications of the proposed treatment on a consent form can be another important step along the patient's journey of informed consent. GDC guidance on consent advises that a written treatment plan and cost estimate is essential.

The process of obtaining consent becomes altogether more complicated when it is unclear if a patient has the capacity to make a decision about their own treatment, often because of their mental health or their age. A patient must be legally competent to grant valid consent. Any adult over the age of 16 is assumed to be competent unless a lack of capacity can be established. A child under the age of 16 can grant valid consent if they can show sufficient maturity and intelligence to understand the nature and purpose of what is being proposed. But in all circumstances, capacity for consent requires that the patient is able to:

- comprehend what the treatment is and its purpose when explained in simple non-technical language
- understand the principal benefits, risks and alternatives
- understand in broad terms the consequences of not receiving the treatment
- retain the information long enough to make an effective decision
- believe the information
- exercise free choice.

Assessing capacity is not straightforward and you should always follow guidance or seek advice from a senior colleague or MDDUS adviser. Regardless of the decision you make, detailed patient notes are a must.

A thorough process of informed consent will establish a rapport and trust between you and your patient. This will not only prepare the patient for the treatment they are about to embark upon, but will help improve communication and understanding if complications arise.

Martin Nimmo is a dentist at the Harley Street Dental Group, London and editor of SoundBite

A TRADITIONAL REMEDY

Opinion is divided on the effectiveness of homeopathic dentistry

HOMEOPATHY is usually thought of in terms of medical treatment, but homeopathic dentistry also has a long tradition and the practice is promoted by the British Homeopathic Dental Association (BHDA). Although the study of homeopathy is not mandated by the General Dental Council, BDS graduates will have heard quite a lot about this system of alternative medicine in the news over the last couple of years. Many people believe homeopathy has no place in the modern era of evidence-based practice, but many practitioners and patients genuinely believe that homeopathy works. So who is right?

Basically, homeopathy is a type of alternative medicine that aims to "treat like with like" using extremely high dilutions of particular substances. In fact, because most homeopathic remedies have been diluted so much, often no molecules of the "substance" in question actually remain.*

One remedy commonly used by homeopathic dentists to treat trauma is arnica, but homeopathic arnica will probably have no arnica in it whatsoever. One might expect the Medicines and Healthcare products Regulatory Agency to clamp down on the use of such potentially misleading descriptions, but the organisation avoids this charge by claiming that such "remedies" are recognised within the homeopathic tradition.

It is due to the implausible nature of the mechanism of homeopathy that the practice has come in for so much criticism. How can the remedy have any effect if there is no active ingredient? And even if there were, what effect is it supposed to exert on the patient?

Homeopathic dentists argue that remedies can be used as an effective complementary treatment to dental surgery to help treat pain, discomfort, bleeding and inflammation. There are also more advanced levels of homeopathy where remedies are used in efforts to prevent or limit infection or complications following surgery. In a recent article in *Dentistry* magazine, one of the founders of the BHDA Dr Philip Wander said: "Homeopathy can play a major part in dental care in conjunction with conventional dental practice which, of course, includes regular check-ups."

Exactly how remedies affect patients is a matter of debate. Some homeopaths admit that there may be no effect beyond that of placebo – where the patient believes the treatment is beneficial and this helps them feel better, even if there is no direct medical or dental effect.

Others insist that there is substantial evidence that homeopathy has an effect beyond that of placebo, and refer patients and sceptics to hundreds of studies that appear to prove this. However, science writer Ben Goldacre and others argue that virtually all of these studies were flawed in some way or were unable to be replicated independently. The current scientific consensus (and the view of the British Medical Association) is that homeopathy does indeed have no effect beyond that of placebo.

"If homeopathic treatments help patients by generating a placebo effect, why should anyone object?"

But if homeopathic treatments do help patients by generating a placebo effect, why should anyone object to this? Problems arise if homeopaths knowingly misrepresent the facts to patients and imply that homeopathic remedies have an active effect if, in fact, they have not. All dentists know that informed (and voluntary and competent) consent is essential if they are to respect patients' rights. Patients must be provided with accurate and relevant information in order to reach a decision.

It is imperative that practitioners are honest when offering patients a homeopathic remedy. Practitioners cannot truthfully claim, for example, "this will cure you" because the remedy will not do that. They could certainly say that "some people with your condition have felt better after taking this treatment", although some would even object to the use of the word "treatment" as it implies an actual effect. In essence, the rules of medical ethics forbid the prescription of placebos to patients in any context other than clinical trials. So if it is accepted that homeopathy is no better than placebo, it should also be accepted that it should not be offered as a treatment to patients.

The NHS does not spend much (currently around 0.001 per cent of its total annual drug budget) on homeopathy, and it has been suggested that funding for the practice should continue if patients want the treatment. But as already stated, this could be perceived as the funding of prescriptions of placebos on the NHS. Some homeopaths argue that more research is needed into whether homeopathy is more effective than placebo and, if evidence to this effect can be found, homeopathy can be accepted as evidence-based medicine. But as a comedian once said, "there's a name for alternative medicine that's been proven to work. It's called medicine." It remains to be seen if homeopathy will eventually make this transition, but if a patient ever asks you for a homeopathic remedy, it is your professional duty to be open and honest about its effectiveness.

**Some remedies are termed "homeopathic" despite containing relatively large quantities of active ingredient; these can indeed have a causative effect on patients, but most homeopathic treatments do not.*

David Shaw is a lecturer in Ethics in Relation to Dentistry at the University of Glasgow's dental school

STEP BACK IN TIME

Head of the BDA museum, **Jason Finch**, looks at some fascinating objects that help tell the story of dentistry

IT began in 1919 with a box of old dental instruments that had been stored under the bed of Lilian Lindsay, the first woman to qualify as a dentist in the UK. Since then, the collection at the BDA Museum has grown steadily and there are now around 25,000 items including dental instruments and equipment, furniture, photographs, archives, fine and decorative art.

Together they paint a colourful picture of the history of dentistry and the many contraptions and innovations that have developed over the years. Trainee dentists today might find it hard to believe that Dr Edward H Angle's Head Gear *(image 3 above right)* was ever used in orthodontics. The cumbersome silk net cap sat on the back of the head and was laced to a metal band while the traction bar and contraction arch at the front of the mouth drew in protruding incisors. A far cry from today's near-invisible devices.

The British Dental Association (BDA) was founded in 1880 and is the professional association and trade union for UK dentists. The fact there is a BDA Museum comes as a surprise to many, but members have always been interested in the history of their profession.

"The collection shows how much has changed in dentistry and how much has stayed the same"

Community reach

Though developed primarily for members, the museum opened its doors to the general public in 1967 when the BDA moved to its present headquarters in Wimpole Street, London. In autumn 2005 the museum was redisplayed with the aim of making it even more accessible to the public as well as dentists. Today the museum runs an active schools education programme, offers a number of benefit services to BDA members and is always looking at ways to increase access to its collections, including the use of QR Codes to engage smartphone users.

My role as Head of Museum Services is to lead the museum, develop its services and, with the rest of the team of staff and volunteers, organise an annual series of exhibitions. We take part in community and heritage events in London as well as the BDA Conference, whilst in 2011 we were at the Scottish Scientific Conference. The museum is part of the London Museums of Health and Medicine group, which works to place the history and development of medicine and healthcare in its widest context. Coming from outside the world of dentistry, working at the museum has been an amazing experience and an incredibly educational one. I was surprised to learn it is a relatively young profession and that it was only the 1921 Dentists Act which finally stopped unqualified people entering the profession.

The museum's varied collection shows how much has changed and how much has stayed the same. A range of Victorian toothbrushes displayed alongside their modern descendants show that, despite technological advances, the basic design has not changed. And the same applies for many of the dental instruments. It may (or may not) be reassuring to trainee dentists that the basic designs of some tools of their trade are not greatly different to those used in 1881 by the first BDA president Sir John Tomes – although modern tools are unlikely to have carved ivory or bone handles.

Familiar story

The museum is primarily about the history of dental care but that does not mean it lacks contemporary meaning. Children's dental health is currently an issue of concern for dentists as recent research claims 18 per cent of parents said their children only brush their teeth once a day, if that! This problem isn't new and echoes concerns expressed in the late 19th and early 20th centuries. Back then, toothbrush clubs were started in schools and a programme of public dental hygiene promotion was launched. Oral hygiene education continues to this day, the museum's own schools programme is part of

it, but perhaps it is time to create a modern version of the old toothbrush club?

The museum also tells the story of individual dentists who left their mark on history, including the rather unlucky George Harrington. In 1864 Harrington invented the first clockwork drill *(image 1 left)* and called it "Erado" (from the Latin meaning 'I Scrape Out'). Whilst it was a vast improvement on the hand drill, its hand-wound mechanism only ran for two minutes and it was heavy, noisy, vibrated too much and was awkward as it required both hands to operate. Harrington improved the design and in 1870 decided to take it to the US, then at the forefront of dental practice. The story goes that whilst at sea, Harrington received a telegram saying American dentist James Morrison had just invented the foot pedal-powered treadle drill. Faster, quieter, needing only one hand to use and lasting as long as the dentist could pedal for, the treadle drill ended Harrington's design ambitions. Whilst this was good news for patients, it is impossible to look upon Harrington's drill and not feel a sense of loss that his design so quickly became a footnote in dental history.

The British Dental Association Museum is situated in the BDA offices at 64 Wimpole Street, London, W1G 8YS and is open Tuesdays and Thursdays 1pm to 4pm.

For more information, and to view our online collections, visit **www.bda.org/museum**

Jason Finch is Head of Museum Services at the BDA (providing maternity cover for Rachel Bairsto).

1 *The clockwork drill invented by George Harrington*

2 *A 19th century student dentist's instrument box with six leather lined drawers. It cost 273 shillings in 1875, the equivalent of £1,000 today*

3 *Edward H Angle's Head Gear, extra-oral appliance*

4 *A 19th century phantom head with 24 natural teeth*

5 *Anaesthetic inhaler designed in 1877 by John Clover. It was the first device to regulate the amount of anaesthetic a patient inhaled*

PHOTOGRAPHS: BDA MUSEUM

A FUTURE IN IMPLANTS

Implant dentistry has become an important feature of primary dental care. **Dr Simon Wright** of the Association of Dental Implantology looks at the opportunities available

OPTIONS, options, options – that is all we dentists seem to hear about. Not only must we ensure our patients are aware of all the options, but also the advantages and disadvantages of all the relevant treatment modalities. And then there is the process of informed consent to contend with. As dentistry becomes more and more litigious, and treatments more complicated, it can leave the patient as confused as a cow on Astroturf.

And that is just the patient. What about you, the young enthusiastic dentist? Not only do you need to worry about your patients, you also have a career to plan which brings with it a further array of confusing options. All of a sudden the cow looks all-knowing, and you start to look out of the window at the rolling fields surrounding your student bedsit, day-dreaming of driving the latest Massey Ferguson tractor, thinking: "stuff it, I'll become a farmer!"

However, before you rush out to buy the latest pair of designer Wellingtons, rest assured that things are not that bad. The Dental Foundation Training programme is an excellent, well organised, structured year that allows you to experience many career opportunities. By the end of it you are more equipped to make informed decisions about the rest of your life and the thought of making an abrupt career change into farming should be a distant memory.

Necessary skills

Implant dentistry is certainly one career option that offers both challenge and reward to a young dentist. It can produce great results for the patient and dentist and can also be financially beneficial. But how do you know if it is for you? The skills and qualities needed for implantology include:

- Basic surgical experience
- In-depth understanding of the periodontal tissues
- In-depth understanding of medical histories
- Commitment to postgraduate and on-going education
- Patience
- Empathy
- Thorough knowledge of all treatment options and the ability to explain these in an impartial, objective manner
- Effective team participation/management
- Forward planning and organisation
- Commitment
- Confidence in own ability
- Ability to manage patient expectation.

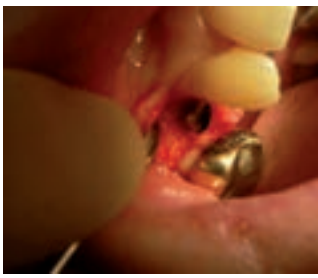
Even if your skill set does not naturally lead you towards dental implants, it is important that you know the essential principles. That way you can properly advise your patient and guide them through the consent process. For dentists there are three broad options to consider when it comes to implant dentistry: recognise and refer all implant cases; recognise and refer the surgical phase but restore implants that have been placed by a trained surgeon; or undertake both the surgical and restorative components.

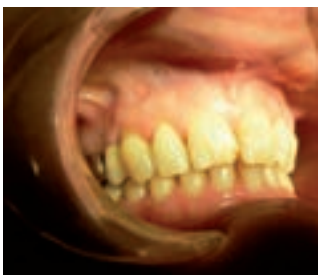
Placing dental implants is a surgical procedure which should only be carried out by a suitably trained dentist. Not all dentists who want to offer implants have to place them and those who are not comfortable with the idea of doing the surgery can consider teaming up with a suitably trained partner who is.

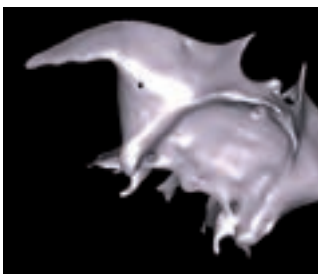
Getting started

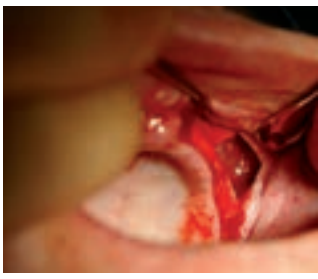
The ADI (Association of Dental Implantology) can simplify the options and guide you through the postgraduate requirements that are needed for you to undertake implant work. Since its formation in 1987, the ADI has been dedicated to providing ongoing postgraduate education to the dental profession in order to extend awareness of dental implant treatment as an option for improving patient oral health. Its range of educational opportunities is varied, from specialised implant journals to masterclasses, evening study clubs to international congresses. Problems can be discussed on a secure clinical forum and increasingly important implant audit facilities (Implant Logbook) freely accessed. Members can also access a membership directory, a monthly ADI e-update and will receive a certificate of membership.

The guidance *Training Standards in Implant Dentistry 2008* from the Faculty of General Dental Practice (UK) and the Royal College of Surgeons of England sets out the requirements that are needed to undertake implant work. It states that the clinician must have a detailed knowledge and understanding of dental implants, be mentored, have the appropriate indemnity and keep a log of cases and

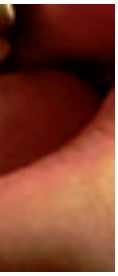




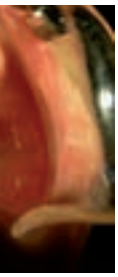


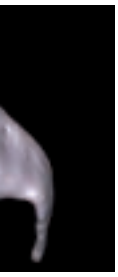


PHOTOS: DR SIMON WRIGHT



Simple case: *Implant placement with no grafting*





Complex case: *Block grafting and bilateral sinus lift, with particulate xenograft - BIOS (cow bone)*

outcomes. It further states that you, the clinician, should develop systematically, ensuring competency in the more straightforward cases, before going on to treat the more complex patients. The General Dental Council has confirmed that it will refer to these guidelines when assessing complaints against dentists who are accused of practising implant dentistry beyond their competence.

It is clear that formal training is needed to fulfil these requirements. There are many different and excellent courses available to you. These include privately and commercially run courses, online courses such as Ark, diplomas at university and the Royal College of Surgeons, and at MSc level.

A good approach to implant dentistry is to firstly ensure that you fulfil the desirable qualities, then try to get as much exposure and experience as you can. Implantologists adore being observed and welcome young dentists who want to get involved with treatment planning, observing the surgery and restorative stages, and being actively involved in the very important maintenance phase.

Once you have started gaining experience and understanding, enrol on a private course (the commercial implant companies or the ADI can help you decide which is best for you), then as you progress undertake formal qualifications from a university or Royal College. This of course can be done alongside your generalist responsibilities and other postgraduate qualifications.

If implant dentistry is suited to you and you are willing to commit to the ongoing education and approach it in a structured well-organised manner, slowly building up your competence, experience, formal knowledge and skill base, all under the supervision of a qualified mentor, then the opportunities are vast. These include professional respect, patient satisfaction, remuneration, and personal fulfilment.

Soon you will no longer look out of the window of your fantastic implant surgery and contemplate becoming a farmer. You will look at cows in the field not for their milk, but for their femur bone graft material that is used to support your implants.

Dr Simon Wright BDS MSc PGCTLCP PGDip Dental Implantology FHEA is principal partner with Glencairn Practice Group, senior lecturer University Salford Dental Implantology, Director of Education at the ADI and chairman of the Local Engagement Network for Wirral PCT

Zoe Wray, studying for a Masters degree in implant dentistry

- **What inspired you to take up implant dentistry?**
  I have always had an interest in oral surgery having worked as a maxillofacial SHO for two years after my vocational training. Implantology seemed a natural progression. I also realised that other methods of replacing missing teeth were outdated by implants, and that in most cases the disadvantages of these methods far outweigh the advantages.

- **Did you find the training a challenge?**
  Yes. Finding training courses that are worthwhile undertaking is difficult. There was not a network of mentors available when I trained, which there is now.

  The MSc in implantology has been very useful, providing me with the skills to assess current advances in the field. My training will be on-going. There will always be advances in implant dentistry and it will always be necessary to be aware of these and put them into practice.

- **What did you enjoy most about it?**
  I enjoy meeting colleagues, being able to discuss cases with them and how they implement processes, policies and procedures in their practices and also finding out and evaluating the evidence behind my everyday implantology work. I hadn't realised that there are very limited studies in the field and there is a lack of good quality studies to underpin our work.

- **What did you find most surprising?**
  I was surprised at the lack of formal training available, especially recognised hands-on courses.

- **Do you see any downsides to the practice of implant dentistry?**
  Yes, as I've mentioned before there are issues surrounding training. Dentists can undertake implant dentistry with very little extra training and there is limited support available. I think that implantology is all about treatment planning. Anyone can place an implant, that's the easy part, but if the case is not treatment planned correctly then big mistakes can be made.

- **What attributes do you feel are important in implant dentistry?**
  I think it is important to have good communication skills. It is also beneficial to have a good foundation in restorative dentistry as well as surgical. Being able to treatment plan and build-in contingency measures is also a useful attribute.

- **Is there one piece of advice you could give to a dentist considering further training in implant dentistry?**
  I would advise anyone who is interested in following this particular path to research the courses available and make sure you select the right course for you. This might involve having to go on several different courses before you find the one that suits you. The MSc I'm undertaking is not a hands on-course and you benefit from it most if you have already had hands-on experience.

BEING YOUR OWN BOSS

Trainees who hope eventually to set up their own dental practice should carefully consider the pros and cons, says MDDUS dental adviser **Claire Renton**

IT MIGHT seem quite early in your career to start thinking about setting up your own practice but it's something that will likely cross your mind at some stage in the near future. While many practitioners will choose to practise as an associate, a career in dentistry also provides an ideal opportunity to become a partner in your own business.

So how do you decide if branching out on your own is the right move for you? Becoming self employed is not an option that will suit all dentists and each of us have our own views and careers preferences. But before making a decision, it's wise to consider some important factors.

Location, location, location

This is often one of the most important decisions we make in our lives – where to live and work? If you are considering setting up a new practice or buying an existing one, location is just as important as the cost. Often the location of our practice will determine the type of patients we have and the treatments we offer. Practices in a city centre are more likely to have a predominance of adult patients who fit in dental appointments around their working lives. Are you prepared to work across normal lunchtimes and after office hours to more easily accommodate these patients? Practices in the suburbs are likely to be more family orientated with a mix of families, young professionals and older patients. Would you like this mix in your working life?

By choosing your location carefully, you can also determine factors such as whether the practice will be an NHS practice, mixed or entirely a private practice.

"Being the boss means you can set your own hours and choose who you employ"

Being the Boss

There are undoubtedly some huge advantages to being the boss. It's your choice who you employ, you usually get to choose the best nurse to work with in the surgery and the receptionist will always be smiling and happy to help! You get the chance to set the tone of the practice; you lead the team and direct the progress of the practice.

Simple things like having leave for family events and holidays can be arranged without having to ask for time off. You can set your own hours and no one will question you when you want a half day for Christmas shopping or a round of golf. Critically, your employment is guaranteed and if you are settled in one area of the country then this might be the sensible choice for you.

Being the principal of the practice also means that you choose the dental materials and equipment you want to work with. If you want to try out a new material you can do just that without having to justify the added expense to anyone – except, perhaps, your accountant.

The flip-side of this scenario is the considerable responsibility you will have in this role. Being an employer brings with it a wide range of legal obligations and you will be required to comply with and stay up-to-date with all relevant legislation governing areas such as employment law and health and safety. These obligations will, amongst other things, dictate how you go about hiring and firing staff, how you treat them during their employment, the policies you must have in place and the type of practice environment you will be expected to provide for them.

As a member of MDDUS you have the added benefit that we are the only defence organisation that offers a free in-house employment law advice service for members who have employment responsibilities as well as for practice managers within MDDUS group schemes. This offers invaluable expert assistance in this often complex area, helping to ensure things will run smoothly for your practice.

If you decide to set up your own practice you will also be responsible for the financial management. Employees must be paid on time, the bills need to be settled and your income and outgoings will have to be monitored closely. You will have to set up a system to ensure that these obligations – as well as the many other financial duties you will have – are fulfilled. Of course your staff can help immensely with these tasks and your accountant is likely to offer a simple payroll solution for the staff salaries, but at the end of the day you are in charge and the buck stops with you.

The main advantage of running your own practice is that you have far more control over your income than you would have as an associate. You are in a position to engage associates of your own in the practice and although you might not make a huge profit from their endeavours the accumulating goodwill and expansion is yours for the future.

Investment choice

So if you decide to become the boss what further choices do you have to make? Well, besides location, the biggest one is whether you decide to buy an existing practice or set up a 'squat' practice from scratch.

While it presents a more affordable option, there are some risks to setting up a squat. An initial large outlay for premises and equipment with no guarantee of income is not a prospect to be taken lightly in today's economic climate – it will likely take many months before you start to break even. However, setting up a squat gives you the opportunity to make your mark on the practice from the off, hiring the staff you want and practising your own brand of patient care.

In contrast, the advantages of buying an established practice are obvious. Someone else has done most of the hard work before you and you start your life as a principle with an established business and a fairly guaranteed income in a practice which the local community recognise. Of course, if this is what you chose to do it's important that you ensure the departing principle is not going to set up a squat down the road and take all the goodwill with him. Your solicitor will advise you of clauses to include in the sale agreement to prevent this from happening. The other big advantage is that the staff generally stay when a practice changes hands. This can be invaluable as patients feel a continuity of care and the transition from the previous principle to you is made more easily. Setting up in this way, however, is perhaps initially the more expensive choice although banks are sometimes more likely to offer a loan for the purchase of an existing well-established business than for setting up a squat with no likely income for a while.

There is obviously a lot to think about and a lot of decisions to be made here. We are lucky as dentists that this profession offers a huge variety of career opportunities.

So which ones will you take advantage of?

Claire Renton is a dental adviser at MDDUS

KEEPING AN OPEN MIND

Dentist **Dr Mike Gow** explains some of the ways hypnotherapy can be used in day-to-day practice

TODAY was a momentous day in my 4½-year-old boy's life. It was his first time watching *Star Wars*. There are interesting moments in the film when Obi-wan uses 'Jedi mind tricks'. Consider the following scene, which I am sure you, like me, know well:

Stormtrooper: Let me see your identification.
Obi-Wan: [with a small wave of his hand] You don't need to see his identification.
Stormtrooper: We don't need to see his identification.
Obi-Wan: These aren't the droids you're looking for.
Stormtrooper: These aren't the droids we're looking for.
Obi-Wan: He can go about his business.
Stormtrooper: You can go about your business.
Obi-Wan: Move along.
Stormtrooper: Move along... move along.

My son asked: "Wow Daddy, how did he do that?"
I answered: "It's called hypnosis."

Hypnosis is essentially the ability to create change in another person's thoughts, feelings and behaviours by using suggestion. Rather than being subjected on 'the weak minded', as suggested in *Star Wars*, it is more accurate to say it's effective with people who are open minded, motivated and expectant, and in accordance with their core ethics, beliefs, desires and morals. This can occur during a trance-like 'state', but hypnotic techniques and language can also be effectively used in day-to-day situations. Medical and dental patients, for example, are often in a more suggestible frame of mind when seeing their clinician. In the main, they want to get better and are looking for help and guidance to achieve this and/or accept treatment. Patients will therefore often respond well to appropriate suggestions and language.

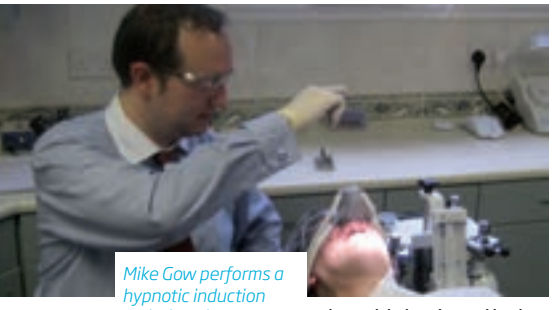
Accentuate the positive

Positive language is important. For example, if I ask you not to think about an elephant in the next 20 seconds, regardless of whether it is an Indian or African, you will find that you have to think about it. The task becomes harder if I also ask you not to think about a toy elephant or carving of an elephant, and to especially not think about the tusks. It is almost impossible not to think of elephants, isn't it? This concept is actually the flaw in Obi-Wan's mind trick, and is why it would be unlikely to work in reality. By saying 'these are not the droids you are looking for', Obi-Wan uses negative language

that draws attention to the fact that these might be the droids the Stormtroopers are looking for. The following discourse would likely have had better success in reality:

Stormtrooper: Let me see your identification.
Obi-Wan: [with a small wave of his hand] You see, his identification is in order.
Stormtrooper: His identification is in order.
Obi-Wan: And the droids you are looking for are somewhere else.
Stormtrooper: The droids we are looking for are somewhere else.
Obi-Wan: So, he can go about his business.
Stormtrooper: You can go about your business.
Obi-Wan: Move along.
Stormtrooper: Move along... move along.

In this case, Obi-Wan's initial response matches the use of the word 'see' although as its meaning is different this would likely cause momentary mild confusion. The following positive suggestion 'his identification is in order' is therefore more likely to be accepted as this is easier to process. The acceptance of this initial suggestion is facilitated by the hand movement distraction technique. Obi-Wan then uses the word 'And' at the start of the next suggestion. As the first suggestion was accepted, the word 'and' implies that the second suggestion 'the droids you are looking for are somewhere else' is also true. This alternative phrase uses positive language that deflects the Stormtroopers' search away from these droids to 'somewhere else'. Likewise, the word 'so' suggests that, as the first two suggestions are true, the fact that 'he can go about his business' is the obvious conclusion.



Mike Gow performs a hypnotic induction technique in combination with inhalation sedation and acupuncture

The use of positive language and understanding language patterns is useful in day-to-day practice. For example, if we tell patients 'Don't worry, it won't hurt', they will remain more anxious than if you had said 'Relax, everything will be fine'.

Similarly, avoid emotive words such as 'pain' and 'extraction', instead using words like 'pressure' and 'removal'. Dissociation often helps when working with anxious patients and changing the word 'your' to 'the' can have a noticeable dissociative effect. So, rather than saying 'I'm going to extract your tooth today', say 'The tooth will be removed today'.

The word 'try' should also be avoided as it implies failure. 'Try to relax' implies that the patient will fail or at least find relaxing very difficult. 'Allow yourself to relax' is more positive, while remaining permissive. You can also use 'lounge' rather than 'waiting room' and 'consultation room' rather than 'surgery'.

Learning techniques such as these has allowed me to find ways of seeking informed consent from patients for certain procedures, ensuring they understand the information and potential risks, without terrifying them into refusing. Often emotive words have to be used to make risks clear, but avoid personalising. Rather than saying 'you might experience swelling, bruising, pain or numbness...', say 'Some people experience swelling, bruising etc...'

There are hundreds of examples of how simple changes in your language can affect the outcome of patient interactions. Combined with rapport building techniques, these form the backbone of successful dental hypnosis.

Evidence base

Hypnosis has been around in various guises for almost as long as humans have been able to communicate. In the late 18th century, Franz Anton Mesmer mistakenly believed the trance-like phenomenon he was creating was due to 'animal magnetism'. It was Scottish medic James Braid who first suggested the phenomenon was psychological. In 1842, he popularised the term 'hypnotism' (from Hypnos the Greek god of sleep).

Huge advances were made in understanding hypnosis in the 20th century but still it was considered by many as 'quackery'. Research is vital to gain credibility and in recent years the evidence base for the nature of, effects and efficacy of hypnosis has rapidly grown in peer review publications. It is important that medical and dental professionals become aware of this work.

It is also important to distinguish medical hypnosis from the stage hypnosis seen on TV and in live shows. Despite some similarities in the hypnotic processes, there are many differences in dynamics such as the social expectations and pressures. Illusionist Derren Brown discussed certain aspects of hypnosis in his recent TV show, *The Experiments*. Despite the seemingly dramatic, and dare I say entertaining results, it's fair to say they do not exactly meet the rigorous standards one would expect from an evidence-based experiment.

In practice

I have successfully treated hundreds of dental cases using hypnosis, and once even hypnotised a patient for the BBC who had extractions and implants with no local anaesthetics. The applications of dental hypnosis are varied and include:

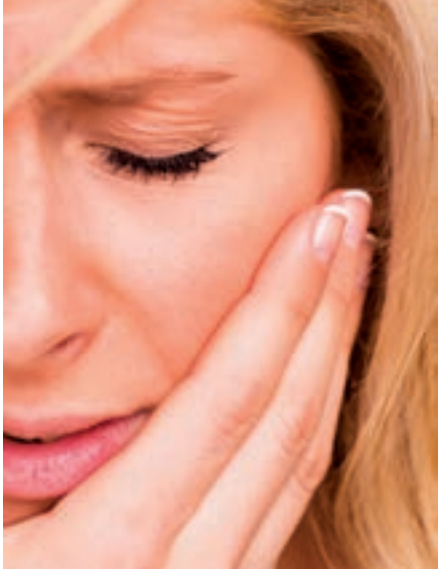
- anxiety & phobia management
- complementing conscious sedation
- gagging
- bruxism
- TMJ dysfunction
- oral habits (e.g. thumbsucking, nail-biting)
- pain (Acute, chronic, psychosomatic)
- salivation control
- bleeding control
- smoking cessation
- recurrent aphthous stomatitis
- burning mouth syndrome.

But hypnosis is only as effective as the underlying therapy or techniques. Due to a lack of legislation, there are many lay 'hypnotherapists' with no psychological or medical training. While it is relatively easy to hypnotise someone, safe and effective hypnotherapy is dependent upon the appropriate training, experience and skill of the clinician. This is as true for hypnosis as it is for the practice of dentistry itself. It is therefore important that dentists seek hypnosis training from recognised organisations such as those listed below.

LINKS

- The British Society of Medical & Dental Hypnosis (Scotland) **www.bsmdhscotland.com**
- The British Society of Experimental & Clinical Hypnosis - **www.bscah.com**
- The Hypnosis Unit UK - **www.hypnosisunituk.com**
- *The Fearful Dental Patient*, Weiner (ed) 2011, Wiley-Blackwell. (See chapter 6)

Mike Gow BDS (Gla) MFDS RCPS (Gla) MSc Hyp (Lon) PGCert (Edin) is a past president of the British Society of Medical & Dental Hypnosis (Scotland), and founded The International Society of Dental Anxiety Management (www.isdam.com)



A RUINED HOLIDAY

This fictional scenario is based in part on a real case in which the missed diagnosis of a dental abscess caused vacation misery and a charge of clinical negligence

DAY ONE
Mrs B attends her dental surgery having made a quick appointment for a broken filling. She informs the dentist – Mr K – that her family will soon leave for a holiday in New York and she wants to get the tooth taken care of before going away. Mr K examines the patient and notes a missing filling in a lower right molar. The cavity is deep but there is no exposed pulp or undue sensitivity. In the limited appointment time available Mr K decides to place a temporary glass ionomer filling with Dycal in the base. Two appointments are made for Mrs B for after her return from holiday to treat the tooth with a bonded crown.

DAY FIVE
Mrs B attends the surgery again for an emergency appointment two days before she is about to fly out on holiday. Mr K finds that the temporary filling has fractured. Mrs B makes no mention of any pain according to Mr K (though she will later dispute this). The dentist replaces the fractured part of the filling with a Cavit dressing. He is confident this will tide her over until further treatment can be carried out on her return from holiday.

DAY TWENTY
Mrs B returns to the surgery for another emergency appointment. She reports her holiday was a disaster. She began to experience pain in the tooth on the flight out. Within a few days the toothache had became unbearable and her face grew swollen. She attended the emergency department at a hospital near her hotel and was told she had a dental abscess. A doctor prescribed antibiotics and strong pain killers. Mrs B is angry and states that her travel insurance only paid a portion of her emergency treatment and she demands that the dental surgery pay the balance of costs. Mr K advises Mrs B to contact the local PCT in respect to re-payment of her holiday expenses. Mrs B leaves the surgery and later fails to turn up for the previously booked appointments.

DAY TWENTY FOUR
Mrs B registers with a new dentist and attends that surgery where radiographs reveal an abscess in the suspect molar. Root canal treatment is undertaken to resolve the infection along with the fitting of a metal crown.

A few weeks later a letter of claim alleging negligence is received at Mr K's surgery from a solicitor acting on behalf of Mrs B. The letter charges that Mr K failed to recognise the infection in the tooth on two occasions and that X-rays should have been taken to confirm the condition of the tooth before undertaking the temporary fillings. It would have then been obvious that immediate root canal treatment was required.

Mr K contacts MDDUS and a dental adviser requests copies of the patient records for review. It is discovered that there is no record of any discussions with the patient regarding her symptoms. Had it been true that Mrs B did report pain in the tooth on her second appearance at the surgery, further investigation including an X-ray would have been warranted and an abscess would have been diagnosed. The need for urgent treatment would have been discussed and options explored given Mrs B's impending holiday.

The MDDUS dental adviser discusses the case with Mr K pointing out that it is clear that the dentist twice missed the opportunity to diagnose the abscess. The lack of any notes in the patient records regarding the discussion of symptoms meant that any legal defence would rely on the dentist's memory. MDDUS judges that arguing the case in court would be risky and could involve significant legal costs. It is decided with the member's agreement to settle the case for a modest sum with no admission of liability.

Key points

- Ensure adequate information including discussion of symptoms and treatment options is recorded on patient records.
- Less haste in emergency appointments can prevent missed diagnoses.

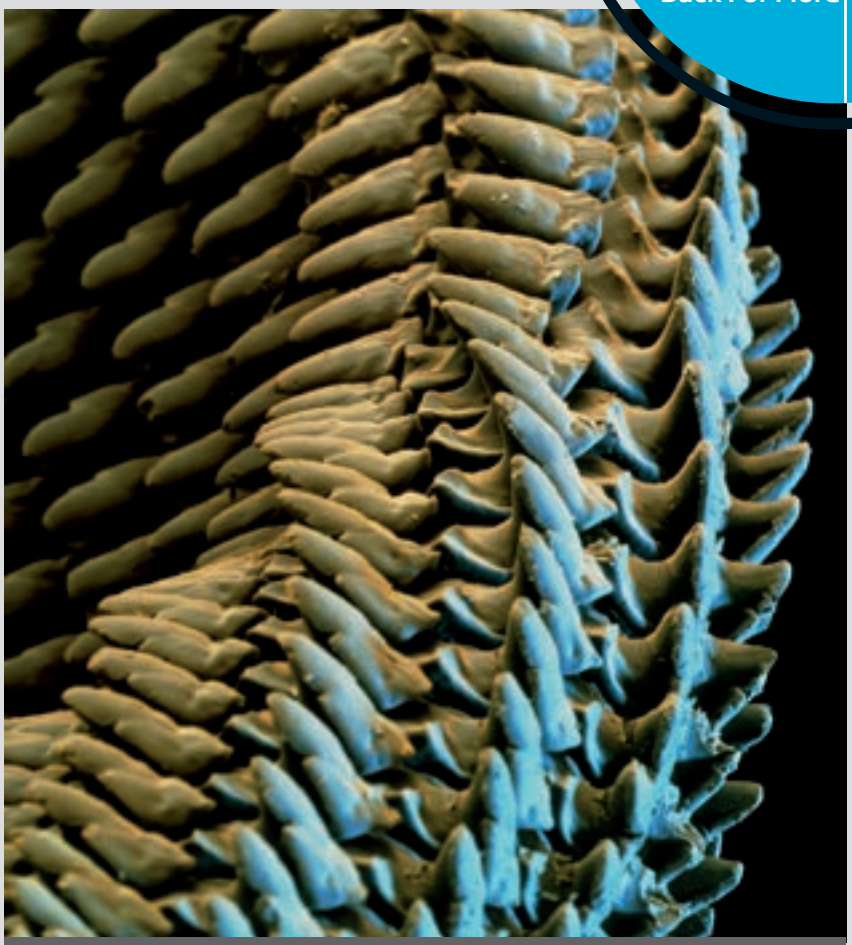
OUT THERE

SNOG AWAY DECAY It's official, kissing is good for your teeth. Scientists say that it stimulates saliva flow which brings down plaque levels. It also helps tone your cheek and jaw muscles and naturally relaxes you because it increases the levels of oxytocin, the body's natural calming chemical. These random facts emerged during this year's National Kissing Day.

DECEMBER DENTISTS **A child born in December is more likely to become a dentist, according to the Office for National Statistics. They reveal the month a baby is born can shape their career as well as affecting everything from intelligence to life-span.**

DENTAL ROBOT A disturbingly life-like 'dental robot' aimed at training dental students has been created by a Japanese company that makes adult entertainment love dolls. Hanako 2 can simulate almost every type of facial movement, can cough, sneeze and even speak. The android can move its tongue and replicate gagging and is about to go into production following trials at Showa University Dentistry School. The realistic silicone skin and mouth lining is courtesy of love doll makers, Orient Industry.

TWEET YOUR PAIN **Twitter has become a popular way for people to share experiences of toothaches and oral health complications as well as searching for dental advice from other users, according to a study published in the *Journal of Dental Research*. Researchers believe social media could be a useful tool for collecting public health data.**



PHOTOGRAPH: SCIENCE PHOTO LIBRARY

NAME THAT BITE

Stumped? The answer is at the bottom of the page

CROSSWORD

ACROSS

1 Collection of abnormal substances within a tissue (4)
4 Grating sound associated with osteoarthritis (8)
7 Epidemiological screening for periodontal treatment (abbr.) (5)
9 Brand-name cavity lining material (5)
10 Colloquial name for the BBC (6)
12 Mythical story (6)
14 Tooth surface facing midline along jaw arch (6)
19 A false tooth (6)
20 Fibre that conducts impulses (5)
21 What the hygienist does? (abbr.) (1,3,1)
22 Brand-name sedative dressing (8)
23 Quantity of matter in a body (4)

DOWN

1 Small, iced, baked treats (8)
2 Worn (6)
3 Not fresh (5)
5 Preserved vegetable (6)
6 WW2 submachine gun (4)
8 Colour slightly (5)
11 Waterfalls (8)
13 Closer (6)
15 Kama _____, ancient lovers' guide (5)
16 Brand-name root canal sealant (6)
17 Paired (4)
18 Devious and underhanded (5)

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

NAME THAT BITE: *Slug radula, SEM*

MDDUS

MDDUS are offering a £1,000 grant to a successful applicant from a dental training practice where both the trainee (commencing training in August 2011) 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 MDDUS by the deadline of January 31, 2012 will be considered.

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