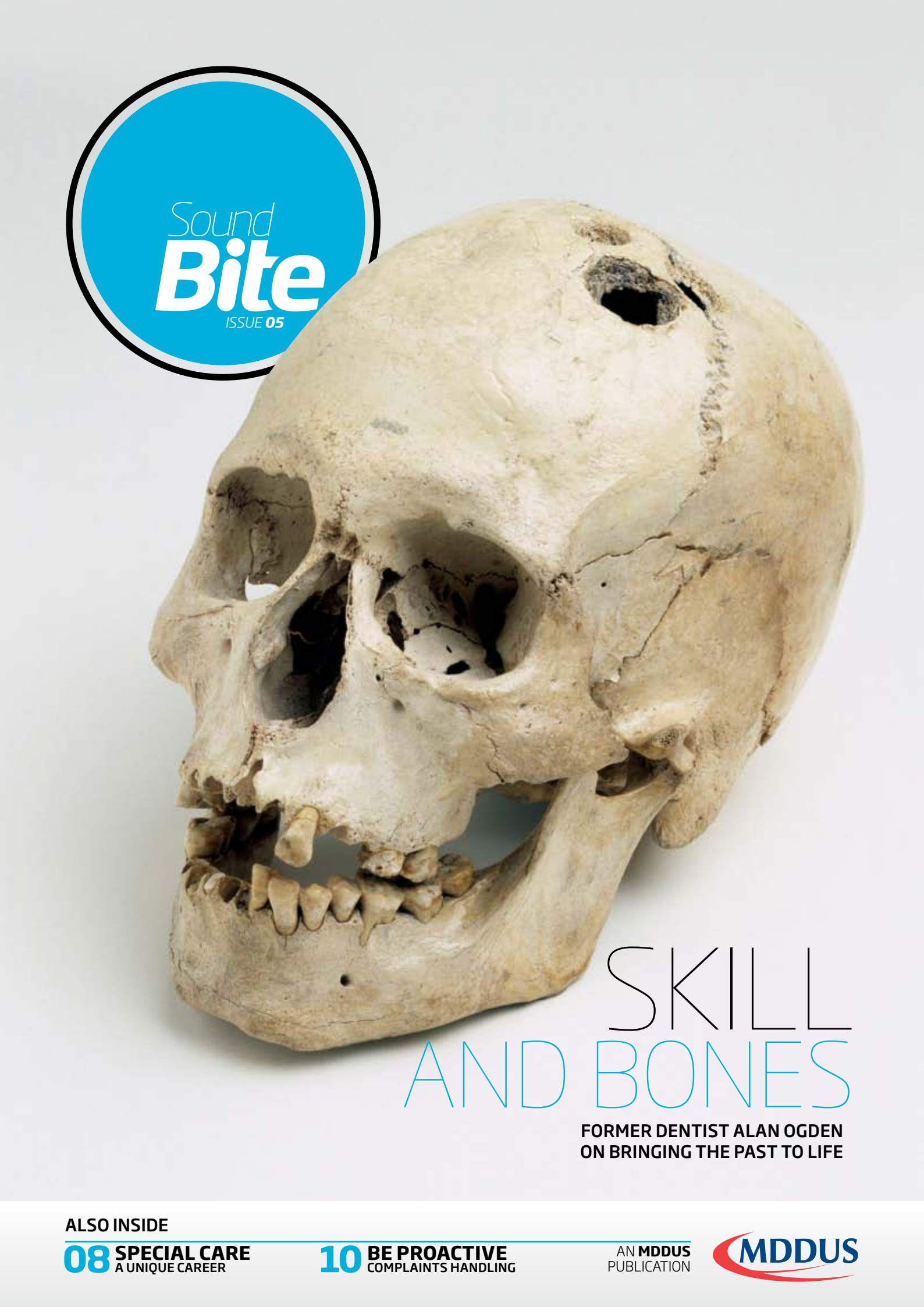
Sound Bite

ISSUE 05



SKILL AND BONES

FORMER DENTIST ALAN OGDEN ON BRINGING THE PAST TO LIFE

ALSO INSIDE

AN **MDDUS** PUBLICATION

PHOTO: ROSLYN GAUNT

Welcome to your SoundBite

THERE'S been a barrage of news items in recent years highlighting the financial and social challenges brought about by the economic downturn. The dental profession has certainly felt the impact and trainees are operating in an increasingly competitive environment. My article on page 4 looks at some of the major issues affecting new dentists and offers guidance on how to stay ahead of the game.

Despite our best efforts, we will all most likely find ourselves on the receiving end of a patient complaint at some point in our careers. Our article on page 10 highlights the importance of swift action in dealing with dissatisfied patients.

Treatments such as teeth whitening and porcelain veneers are becoming an increasingly common dental practice as patient demand for cosmetic dentistry rises. But is it acceptable to destroy healthy tooth tissue to achieve the "perfect smile"? Dental ethicist Dick Birkin discusses the issue on page 5.

Endodontic treatment is an important part of good oral health, but it can be difficult and failure can be costly. MDDUS dental adviser Doug Hamilton highlights some common pitfalls on page 12. Our case study on page 14, meanwhile, looks at the case of a trainee dentist who removed the wrong tooth.

On page 6, palaeopathologist Alan Ogden lifts the lid on his fascinating work studying ancient human remains, where he uses his skills as a dentist to build a picture of how they once lived. He famously reconstructed the features of Gristhorpe Man, one of the best preserved Bronze Age skeletons ever found in the UK.

And in our careers article on page 8, specialist trainees Jane Temple and Jessica Rowley focus on the small but growing specialty of special care dentistry where every patient is unique.

• **Martin Nimmo**
Editor

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DENTAL FRAUD COSTS £70 MILLION OVER YEAR

DENTAL fraud cost the NHS in England over £70 million in the year 2009-10, according to figures published by the government agency NHS Protect.

The report looked at the prevalence of suspected fraud in contractor claims within NHS dental services based upon a random sample of 5,000 FP17 dental activity reports for completed treatments drawn by NHS Dental services. This was the first such exercise undertaken since the current dental contract was introduced in April 2006.

The report concludes that there was an estimated loss due to suspected contractor fraud of £73.19 million during 2009-10 based upon an assessment of resolved treatment queries, with a potential for a further £5.31 million of loss in unresolved queries. It is estimated that during this period almost one million inappropriate claims (FP17s) were submitted for payment.

The types of suspected contractor fraud included patients not receiving the level of treatment on the FP17 (50 per cent), split courses of treatment (27 per cent), patients not visiting the dentist (12 per cent), fictitious patients (10 per cent) and patients paying for treatment but marked as exempt on the FP17 (1 per cent).

The report estimates that without some form of intervention a further £146.38 million could be lost to fraud before the new dental contract is in place in April 2014.

But the British Dental Association has urged caution in interpreting the results. Dr John Milne, chair of the BDA's General Dental Practice Committee, said: "These figures will need to be looked at carefully and understood to ensure that the cases of fraud are distinguished from cases where a course of treatment has been staged for legitimate reasons.

"It cannot be assumed that treatment that has been planned in a phased way, or had to be restarted during what was intended to be a single course, is fraudulent; that simply isn't the case. There are clinical factors that can explain both scenarios."

CPD ON ORAL CANCER

IMPROVING early detection of oral cancer is now a "recommended topic" in the GDC's continuing professional development (CPD) scheme.

CPD is a legal requirement of registration with the GDC but there are currently no mandatory CPD topics. The GDC does identify certain 'core' topics that dental professionals should cover as part of their verifiable CPD, including medical emergencies, disinfection and decontamination and radiography and radiation protection (or materials and equipment for dental technicians).

The GDC also recommends some subjects that can be completed as verifiable or non-verifiable CPD. These are legal and ethical issues, complaints handling and, now, improving early detection of oral cancer.

The GDC is reviewing its CPD requirements and throughout 2012 work will continue to develop a future CPD model, extensive stakeholder engagement and public consultation.

Any new CPD requirements will not be introduced before 2013. More details at: **www.gdc-uk.org**

DENTAL PRESCRIBING APP LAUNCHED

A NEW app to support drug prescribing within primary care dental practice has been launched in Scotland.

Dental Prescribing has been developed for use on the iPhone, iPad or iPod touch and presents advice on the management of a range of dental conditions using a problem-oriented approach.

Drug regimens are displayed in a 'prescription-like' format to aid prescribing for both adults and children in primary care and are linked to the British National Formulary (BNF) website for information on drug interactions. Advice on the management of medical emergencies is also provided.

The app has been developed in collaboration with Waracle in Dundee by the Scottish Dental Clinical Effectiveness Programme (SDCEP), which is part of NHS Education for Scotland (NES).

Dr David Felix, Dean for Postgraduate Dental Education at NES, said: "I am sure that this new way of delivering prescribing guidance will appeal to many in the dental profession and will build on the success, popularity and usefulness of the printed guidance."

The *Dental Prescribing* app is available to purchase from the App Store.

MDDUS YEARBOOK HANDOUTS

MDDUS have been visiting a number of dental schools recently to deliver yearbooks to our graduate members. The yearbook is free if you take up graduate membership with MDDUS, which offers access to dento-legal assistance and professional indemnity for just £10.

We also paid a special visit to the new Aberdeen Dental School where we helped mark the graduation of its first group of trainees by giving our graduate members a free pair of Hogies Eyeguards to help them start their new careers with confidence.

For more information please contact Olivia McCulloch at MDDUS on **omcculloch@mddus.com** or **0845 270 2034**. The yearbook offer applies to all medical and dental schools in Scotland.

DON'T SUPER-SIZE ME

PLANS have been unveiled in New York for a ban on super-sized soft drinks over 16 ounces in a bid to curb rising obesity levels. The law was proposed by mayor Michael Bloomberg's Obesity Task Force who want to restrict sales of sugary drinks. PHOTO: REUTERS/ANDREW BURTON

AVOID SELF-PRESCRIBING SAYS MDDUS


GENERAL DENTAL COUNCIL
www.gdc-uk.org
GDC protecting patients, regulating the dental team
RESPONSIBLE PRESCRIBING

MANY dentists may hold the view that self-prescribing is a convenient aspect of the job and that in writing scripts for straightforward items such as antibiotics they are simply saving time and NHS resources.

But MDDUS has handled cases where dentists have been subject to fitness to practise proceedings for either self-prescribing or for prescribing to a family member or friend. We advise that it is good practice for dentists to only prescribe drugs to meet the dental needs of their patients.

"Self-prescribing is not technically illegal," says MDDUS dental adviser Claire Renton. "But it does raise serious ethical concerns and could ultimately result in a complaint to the GDC."

In its guidance *Responsible Prescribing*, the GDC advises against treating and diagnosing yourself or those close to you. It states: "Other than in emergencies, you should not prescribe drugs for yourself or for anyone with whom you have a close personal or emotional relationship."

There are many reasons for such tight controls on self-prescribing, mainly concerning the loss of objectivity, says Claire.

"Part of prescribing drugs responsibly means prescribing only when you are able to form an objective view of your patient's health and clinical needs. Everyone needs objective clinical advice and treatment.

"Dentists who prescribe drugs for themselves or those close to them may not be able to remain objective and risk overlooking serious problems, encouraging or tolerating addiction, or interfering with care or treatment provided by other healthcare professionals."

So the main message is follow GDC guidance when contemplating whether or not to prescribe for a family member or friend, says Claire. "Even if it is a prescription for something innocuous, you don't want to do anything that might compromise your professionalism and duty of patient care."

Read the full GDC guidance *Responsible Prescribing* on their website at **www.gdc-uk.org**

PUBLIC HAPPIER WITH NHS DENTISTRY

PUBLIC satisfaction with NHS dentistry increased in 2011 for the third year running, a new survey suggests.

The *British Social Attitudes Survey* found satisfaction with dentistry rose by five percentage points to 56 per cent last year, continuing increases seen in 2009 and 2010.

John Appleby, chief economist at the King's Fund (which sponsored the annual poll's health questions), said the rise was likely a "reflection of increasingly better access to dentists carrying out NHS work".

Dentistry bucked the trend seen across the rest of the NHS where satisfaction levels dropped from a high of 70 per cent in 2010 to just 58 per cent last year. This is the largest fall since the survey began in 1983 and follows 10 years of improving results.

The King's Fund concluded that falling satisfaction is less likely to reflect a deterioration in services than concern over the government's health reforms and funding cuts.

More than 1,000 people were surveyed between July and November last year, which coincided with high-profile media coverage of the government's health reforms and the beginning of its squeeze on NHS funding.

AHEAD OF THE GAME

How can dental trainees cope in these increasingly challenging times?

PREDICTED debt levels for dental graduates are expected to more than double from the current average of around £25,000 to as much as £63,000 once the rise in tuition fees takes hold.

The figures make for depressing reading for trainee dentists who are feeling the effects of the economic downturn as keenly as the rest of the healthcare sector.

The seemingly endless gloomy headlines warning of financial hardship are accompanied by equally worrying news of dwindling numbers of jobs, a squeeze on NHS and private practice income and universities struggling to achieve research grants.

Add to that the various other workforce and political factors and it's fair to say young dentists now have to compete in an increasingly challenging environment. So what can trainees do to keep ahead of the game?

One of the biggest issues that will affect the majority of dental students is debt. From this year, new undergraduates south of the border will have to pay up to £9,000 tuition fees per annum.

The British Dental Association has raised concerns that this could limit access to the profession after figures showed people from lower socio-economic backgrounds made up just one in every six applications for dentistry and medicine last year. At present, dental students are graduating with an average debt of £25,545 compared to £16,614 for other students. The current level is already up 128 per cent from 2000 and, given the rise in tuition fees, debts could hit £63,000. Such daunting figures could potentially make entry to the profession a matter of ability to pay rather than ability to perform.

The best thing young dentists can do is to plan your budget early and make sure you stick to it. Work out how much money you have and what your expenditure is likely to be – and be realistic. Research all available funding streams, whether it's low interest student loans, professional bank loans or even charities and sponsorship. For those with money worries, independent advice is available from sources such as the National Debtline (**www.nationaldebtline.co.uk**) or Citizens Advice.

In the long-term, fears over financial problems could change the shape of the dental workforce by deterring some trainees from further postgraduate study. This could impact specialty training, especially in a field such as oral and maxillofacial surgery which requires two undergraduate degrees. It may also reduce the number of young dentists who go on to buy their own practice, perhaps opening the door to an increase in the number of corporate practices. These factors will present their own challenges in time, so it is worthwhile for young dentists to bear in mind that career plans may have to adapt to continually evolving professional settings.

Another major challenge for trainees is job competition. In the not too distant past, a job in the UK on completion of BDS was almost a certainty. Now with an increase in EU applicants for VT/DFT places, competition for these posts is much higher and undergraduates must be prepared to go that extra mile to make an impression. There are a number of clinical and non-clinical activities to participate in which will not only make your CV stand out to potential employers, but will also improve communication skills which are so important at interview.

To stay ahead of the game upon graduation, it is vital to continue relevant postgraduate study and courses. There are a multitude of clinical courses and CPD activities offered by a number of providers. It is important to expand your clinical repertoire with treatments which will not only benefit your patient base, but will offer a return on your investment. In these tight economic times, young dentists must be acutely aware that it is easy to invest vast sums of money in education and equipment which may turn out to be of little practical use.

Given the number of factors which will impact on our future working lives, I would urge young dentists to feedback problems they encounter, and also participate in influencing regulation and policy issues which will have a direct impact on their working life. The BDA has two committees held especially for the representation of students and young dentists. The Young Dentists Committee (YDC) represents practitioners up to 12 years post-graduation from all spheres of dentistry in England, Northern Ireland, Scotland and Wales. YDC regional representatives are contactable through the BDA website, or if a region does not have a representative, concerns can be raised through the BDA centrally.

The BDA Student Committee comprises two students from each UK dental school who champion the needs and wants of students both in terms of policy-making and political lobbying. The Student Committee has been active in looking at issues such as student funding, the vocational training/foundation training application process, and student debt.

Although there is some uncertainty about future aspects of the profession, it is not all doom and gloom. A dental career still has excellent employment prospects and starting salary, especially in comparison to graduates from other degrees. A dentist can still choose between working in private or public practice, and can switch between the two with relative ease. Working hours are fairly flexible, and there are many non-clinical dental activities which can offer a great deal of job satisfaction. There is much to be proud of in our profession, and it is imperative to resist attempts to devalue our clinical services and the dentist's position within the team.

Martin Nimmo is a dentist at the Harley Street Dental Group, London and editor of SoundBite. He is also chair of the BDA's Young Dentists Committee and Student Committee.

THE PURSUIT OF PERFECTION

Is it acceptable to destroy healthy tooth tissue to achieve the 'perfect smile'?

"PRIMUM non nocere" – first do no harm. The Hippocratic oath can be said to apply to dentists as much as doctors. But how does this relate to a world where we surgically change the size and shape of our bodies, decorate our skin with tattoos and piercings and seek the "perfect" smile? And what is the balance between patient autonomy and professional paternalism?

The increase in private dentistry and patient expectations has created new ethical dilemmas. Society has moved from basic dental treatment to advanced restorative treatments. Many of these destroy tooth tissue. Cosmetic dentistry can be defined as a procedure carried out in the absence of dental disease or pathology. Is a patient entitled to have sound tooth tissue removed solely for the purpose of improving the look of their teeth? How should a dentist deal with this ethical quandary?

One way is the 'daughter' or 'partner test' which has existed for many decades. In effect it is the ultimate ethical test of any dental treatment: would you carry out this treatment on the person for whom you care the most?

Patient autonomy

Judge Cardozo stated in 1914 in the case of *Schloendorff v Society of New York Hospital*: "Every being of adult years and sound mind has a right to determine what shall be done with his own body." However, the rise in patient power poses the ethical question of where the border lies between patient autonomy and dental paternalism or 'dentist knows best'? Ethically patients have the right to make bad decisions. But the final judgement is with you, the clinician. If you do not feel ethically comfortable with a line of treatment you should not carry it out.

The patient may, when older, regret a treatment that shortens the life of a tooth. But also it could be argued that the short-term benefit of a treatment may outweigh the longer term downside. Life-changing personal or professional events can be attributed to improved aesthetics and improved confidence. Who are we to take away the patient's right of autonomy?

Informed consent and record keeping

As with much ethics, there is no right or wrong in this issue. The decision may rest with the patient in assessing the degree of personal benefit and dental loss expected by the procedure. But it is essential that the dentist discusses this decision as part of informed consent. Most importantly, this process should be DOCUMENTED. If a procedure goes wrong or does not meet patient expectations the first accusation will probably relate to the patient denying that informed consent was obtained. It is then that you and your defence organisation will have to prove that it was. What should you do? First, contact your defence organisation, second, contact your defence organisation, third... Never ever reply to a complaint or accusation about the quality or necessity of your treatment without consulting your defence organisation.

The lack of clinical necessity for a procedure makes the consent process the key event. Research shows that it is actually quite rare for patients to remember all that they were told. In his 2006 study, 'Informed Consent – a contemporary myth?', Professor R Lemaire wrote: "A number of studies have shown that retention of medical information is at best fragmentary, and that it is selective and decreases over time".

Your records are key to demonstrating this. You have 2,000 patients; the patient has one dentist. If it comes to a judge deciding whose recall of events is better they may well take the patient's opinion. However, good clinical records explaining what was offered and why, detailing options, alternatives (including doing nothing), success rate, costs, benefits, risks, side-effects, complications, aims, rationale, what is involved, likely consequences, limitations, risks and advantages for all possibilities will provide a sound defence. The more complex and expensive the treatment you provide the more you should write in your records.

GDC guidance

In its guidance *Principles of patient consent*, the GDC advises that you should always provide a written treatment plan and cost estimate. The patient should be given sufficient information, the consent should be voluntary and the patient should have the ability to understand the information given. Profit and personal gain should not be seen as the primary driver of a treatment plan. Putting patient interest first is the GDC's primary principle.

It is important also to allow the patient time to consider the large amount of information you have given them. Use balanced written information and not advertising matter produced by a manufacturer. Try not to speak with abbreviations and technical language. Never pressurise the patient into a line of treatment – even if they ask "what would you do doctor?"

Finally, the more you show you care for your patients the more your patients will believe in you.

Dick Birkin is Secretary of the Dental Law and Ethics Forum and acts as an expert witness to the GDC on regulations and record keeping

Adam Campbell chats with a former dental surgeon now palaeopathologist

WRITTEN IN THE BONES... AND TEETH

IF THE eyes are the windows on the soul of the living, then the teeth, jaws and skeleton are, it seems, the keys to the physique, health and lifestyle of those who are long departed. Be they male or female, labourers or aristocrats, monks or military men; whether (and when) they had suffered from TB, malnutrition or leprosy and even where they grew up – all this information and much more can be divined from the skeletal remains of humans going back deep into prehistory.

"As far back as we have skeletons," says Dr Alan Ogden, a palaeopathologist based in the Department of Archaeological Sciences at Bradford University. "In fact," says the former dental surgeon, "I've just been involved with a human ancestor who precedes homo erectus."

A million-year-old "patient" is perhaps as far away as it's possible for Alan to get from the living ones he was used to dealing with over a long dental career, first in general and hospital practice for 12 years and then at Leeds Dental Institute as a clinical lecturer and specialist in restorative dentistry for another 20. But after hanging up his dentist's drill and smock 11 years ago, this is precisely the subject he has dedicated himself to – using scientific and historical detective work to conjure an image of a person whose life once animated what are now skeletal remains.

"They were real people, they felt the world revolves around them much as we do now. My concern, as much as I can, is to bring them back to life," says Alan.

Bony evidence

The very first job in bringing these people back to life is for Alan and his archaeologist colleagues to try to establish the period from which the skeletons come, as this influences the way in which the information gathered subsequently is interpreted. The habits and diet – and therefore the teeth and skeleton – of a medieval labourer, for example, were considerably different from those of a Victorian factory worker. "We have a whole galaxy of chemical and analytical techniques to help us tell when the bones were buried," he says.

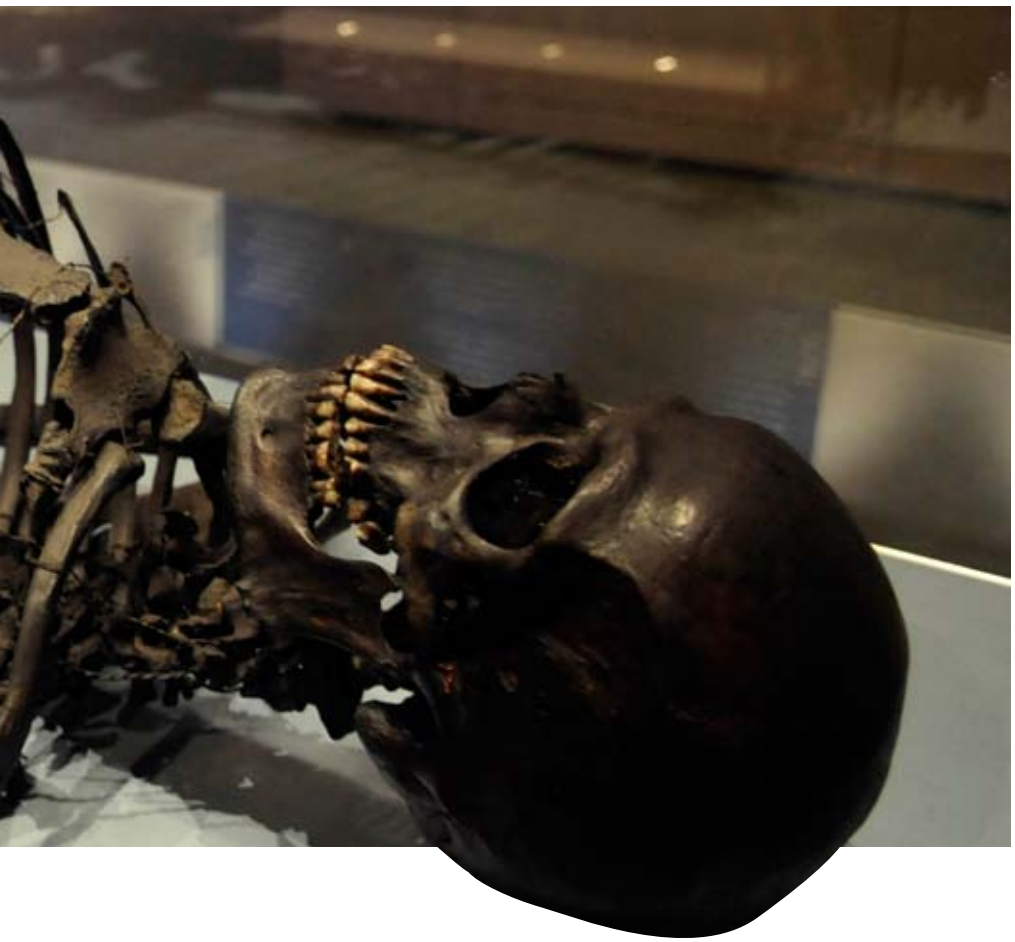
Although he sometimes works on archaeological digs, Alan refers to himself as a "backroom boy", and the painstaking task of examining the remains usually starts with the careful transport of the skeletal material back to his laboratory. There he begins by "eyeballing the bones, using magnification when necessary, and then using X-rays, which will tell us a lot about their internal structure." He also uses CT scanning and nuclear magnetic resonance spectroscopy, among a host of other techniques.

A first clue as to the person's status, says Alan, is the "robusticity" of the bones. "In other words how much they were using their muscles. We get quite characteristic swellings on bones which show that a muscle was pulling on it regularly. And so you get a big difference in build between people who were agricultural or building labourers and, say, monks who spent all their time writing manuscripts. And you'll see signs of ulceration and inflammation in the legs if the people were very sedentary."

Alan Ogden with his facial reconstruction of Gristhorpe Man. PHOTO: TONY BARTHOLOMEW

Diet and origin

Of course, build is just one of many parameters – after all, medieval noblemen, who were often military men, could be fit and strong too. Diet also leaves its imprint on the teeth and skeleton, with the poor during this period eating a much less refined, and therefore



"They were real people, they felt the world revolves around them much as we do now"

Bronze Age skeleton, "Gristhorpe Man".
PHOTO: SCARBOROUGH MUSEUMS TRUST / TONY BARTHOLOMEW

Cover image: Classic palaeopathology: surgical holes (trephination) in a Bronze age skull from Jericho

more abrasive, diet than that of the rich. "The lower down the pecking order you were, the coarser the food," says Alan. This led to a clear difference between the social groups in terms of wear and tear on the molars.

But the results of good living were not always positive: "Sometimes the wealthy overdid it, so if they had a lot of meat, because vegetable food was seen as coarse and for the common people, they became prone to conditions like gout and disseminated idiopathic skeletal hyperostosis," both of which leave characteristic signs on the skeleton.

Other clues in the teeth, such as their isotopic constituents, can point to the geographical area where the individual spent their childhood years. "Essentially, the chemicals embodied in teeth don't change throughout a person's life, thus giving away chemically where you spent your childhood."

When combined with the fact that a person's skeleton is replaced in its entirety every 20 years – and also shows signs of the locality in which the person was living during that period – this allows further conclusions to be drawn. "That's one of the ways we can look at migration, in that the nearer the composition of the bone is to the area where people are found, the longer they have lived there," says Alan.

In recent years, this has led to the overturning of the belief that expeditionary Vikings tended to marry local women. Among the female bones and teeth examined, a discrepancy was found between where they were buried and where they grew up, in this case Scandinavia, showing that Viking men often brought Norse women with them on their travels.

Technological advances are constantly pushing the boundaries and scanning electron microscopy is currently unlocking a wealth of fascinating information held in the enamel of teeth. This has to do with the health of the person at the time the enamel was being laid down.

As Alan explains: "If there are periods of poor nutrition or a child has a high temperature for a fortnight or so, you get patches of substandard enamel. You find grooves in their teeth called enamel hypoplasia, and because we know at what age each part of the tooth was formed, we can say this individual was very ill on several occasions between the ages of about seven and 11."

Facial reconstruction

These are just a few of the many techniques that help to build the detailed picture that finally emerges from the archaeological team as a whole. But articulating that picture to the general public is often difficult, especially when you are dealing with advanced scientific processes and terminology.

However, one means of stimulating the public's imagination is through facial reconstruction. It is a technique that Alan has become adept at in recent years. With a well-preserved skull and knowing the age and sex of the individual, it is possible to arrive at a fairly accurate representation of the person in question. "I still use the old-fashioned method which is to build up the underlying musculature in clay and then build up a layer of skin over the top," he says.

He has famously reconstructed the features of "Gristhorpe Man", probably the best-preserved Bronze Age skeleton in the UK, as well as of those of a leper from a colony in Chichester and a medieval noblewoman buried at Stirling Castle. And as DNA techniques advance, it should one day be possible, he says, to add information on hair, eye and skin colour, making his stated aim of "bringing these people back to life" ever more real.

No complaints

Alan's move into archaeology, a lifelong interest, has been something of a dream realised for the former dentist. While he loved his dental and teaching career, he had always felt a little frustrated by the need to specialise so early in life. "With anatomy, for instance, we learnt head and neck, a little bit of chest and virtually nothing else. And one of the things that I love now is that I know the anatomy of the whole body. The great thing is I can integrate dental anatomy and dental pathology into the bigger picture."

It does mean, of course, that the question of patient contact has taken on a rather different complexion. Does it bother him? Not at all, he laughs. "With skeletons, I can go for a cup of coffee and they don't complain."

Adam Campbell is a freelance journalist and regular contributor to MDDUS publications

TAKING SPECIAL

Special care dentistry trainees **Jane Temple** and **Jessica Rowley** focus on this small but growing specialty where each and every patient is unique

SPECIAL care dentistry is a specialty unlike most others where every day – and every patient – presents their own unique challenges.

The care offered is very much patient-led and takes a holistic approach that considers all aspects of a person's life and medical care. Delivering even the most basic oral care may require careful planning, a variety of sedation techniques and even unusual communication methods.

As a specialty, it is relatively new and quite small, having been approved by the General Dental Council in 2008. Dentists working in the field from 2008 to 2010 could apply for inclusion on the specialist list upon completion of a satisfactory portfolio of evidence.

The first specialty training registrars were appointed in October 2009 by the London and Oxford deaneries and were quickly joined by others across England, Scotland and Wales. There are currently 18 trainees nationally with plans to further expand the number of training pathways.

According to the British Society for Disability and Oral Health, the specialty takes a holistic approach to providing oral care for "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 a number of these factors".

Training

To enter specialty training you should have a BDS or equivalent, completed dental foundation training and it would be advisable to have one of the Royal College examinations, i.e. MJDF or MFDS. Training lasts three years, leading to a Certificate of Completion of Specialty Training (CCST).

The curriculum covers:

- Biological sciences
- Concepts of impairment disability functioning and health
- Behavioural sciences
- Oral health promotion
- Oral healthcare planning for individuals and groups
- Clinical special care dentistry
- Legal aspects, ethics and clinical governance
- Knowledge of research, statistics and scientific writing.

Currently, the curriculum is delivered in different ways depending on the training programme. Some trainees carry out a masters degree as an integral component, but others undertake distance learning either through the Diploma in Special Care Dentistry (DSCD), Royal College of Surgeons of England or the Bristol University Open Learning for Dentists (BUOLD). All trainees need to successfully pass the Tricollegiate Exit Exam (RCS Glasgow) in order to gain CCST.

Trainees are continually assessed through work based assessments and case based discussions with an emphasis on reflective learning. At the end of each year, the trainee must pass an Annual Review of Competence Progression (ARCP).

Some training programmes are hospital-based with elements of primary care experience, but we are based in community dental services under the supervision of primary care consultants in special care dentistry. We also both work within hospital settings, giving a wide exposure and breadth of experience.

Necessary skills

Working in special care dentistry requires a variety of skills, including behavioural techniques, sedation, hypnosis and acupuncture. Each day is different and each patient unique, including the way that we need to communicate with them such as using Makaton or word boards.

Special care dentists need to have a comprehensive knowledge of either the Mental Capacity Act 2005 or the Adults with Incapacity Act (Scotland) 2000 and the notion of informed consent as many patients lack the capacity to make decisions about their own dental treatment. This can be a complex area and laws vary between Scotland and the rest of the UK.

Sometimes, examination of a patient is not possible without general anaesthesia or sedation, so the specialist must be prepared to treat whatever they find. For a patient who has had little or no past dental treatment, their needs may be significant. It may also be necessary to perform a biopsy if suspicious lesions are found. This kind of treatment places demands on the dentist both clinically and physically.

Other areas of special care are concerned with treating those with medical complications such as haematological disorders or those about to start cancer therapy. These cases require close liaison with other medical professionals to provide effective and safe dental care.

For oncology patients, dentistry may not be a priority but a failure to address these issues may have serious long term complications and affect the success of their treatment. The challenge here is to help these patients swiftly with kindness and understanding.

In practice

Special care dentistry is a rewarding career that encourages us to adapt and strengthen our skills, while sometimes 'thinking outside of the box'. While working with special care patients we spend a large amount of time with them and their carers and come to know them as people, not just as patients. No matter how professionally detached a dentist may try to stay we inevitably become emotionally attached to some.

To enter into this specialty is to accept this and ensure that we use these experiences positively to help us to treat patients within the context of their own lives.

Sources:

- British Society for Disability and Oral Health - **www.bsdh.org.uk**
- GDC curriculum - **www.tinyurl.com/boceh7p**
- British Society of Gerodontology - **www.gerodontology.com**
- Special care dentistry training resource: **http://stscd.com/wordpress**

Jane Temple and Jessica Rowley are specialty training registrars with the Yorkshire and the Humber Postgraduate Deanery

CARE

A Day in the life

Below are examples of 'typical' days for Jane who works at Sheffield Salaried Dental Care Services and Jess who works at City Health Care Partnership Dental Services Hull

	Jess	Jane
7:30am		Preparation of domiciliary equipment and travel to homeless project
8:30am	Resuscitation training and practice using the hoist with sedation team	Treat homeless patients with a range of social issues including drugs, alcohol and mental health problems
9:30am	Urgent new patient referral – needs to start radiotherapy in 2/52. Treatment planning in liaison with oncology/ radiology	
10.30am	Intravenous sedation to facilitate examination and all necessary treatment for patient with advanced Huntington's disease	
11.30am	Local anaesthetic extractions for quadriplegic patient who requires hoisting	Home visit for new patient who is repeatedly biting his lip. Patient has cerebral palsy, uses a wheelchair and communicates with a word pad. Liaison planned with speech and language therapists to determine the best treatment
1.30pm	Observe learning disability team on home visit	Observed by educational supervisor whilst providing hypnosis for an extraction, followed by a case based discussion
2.30pm	Lead a best interests meeting for a patient with Down's syndrome and severe congenital cardiac disease	
3:00pm		Inhalational sedation for fillings on a phobic patient.
4:00pm	Case based discussions with consultant and other registrar	Assessment of a patient with Huntington's disease for treatment under intravenous sedation
5:30pm	Finish	

Q&A
Carole A Boyle, Consultant in Special Care Dentistry

• What attracted you to a career in special care dentistry?
I realised that I enjoyed treating people rather than drilling teeth. Unlike now, at that time there was no training path in special care dentistry so I had to make up one as I went along. I enjoy oral surgery and conservative dental treatment and in my current job I can do both but for a very interesting group of patients. Special care dentistry is ordinary dentistry for extraordinary patients.

• What do you enjoy most about the job?
I enjoy the range of patients that I see. One moment I'm talking to somebody who is extremely anxious and phobic of dental treatment but also highly intelligent and knowledgeable. The next I am gaining consent for sedation for someone with a mild learning disability. I also see patients with complex medical histories and trying to work out the best and safest way of providing care for them is incredibly challenging but also very rewarding.

• What do you find most difficult?
The most difficult part of the job is engaging patients and their carers to motivate them to provide simple oral hygiene. It is upsetting to begin every treatment with plaque removal for patients with learning disabilities because their carers do not see the necessity to assist their client in brushing their teeth between appointments.

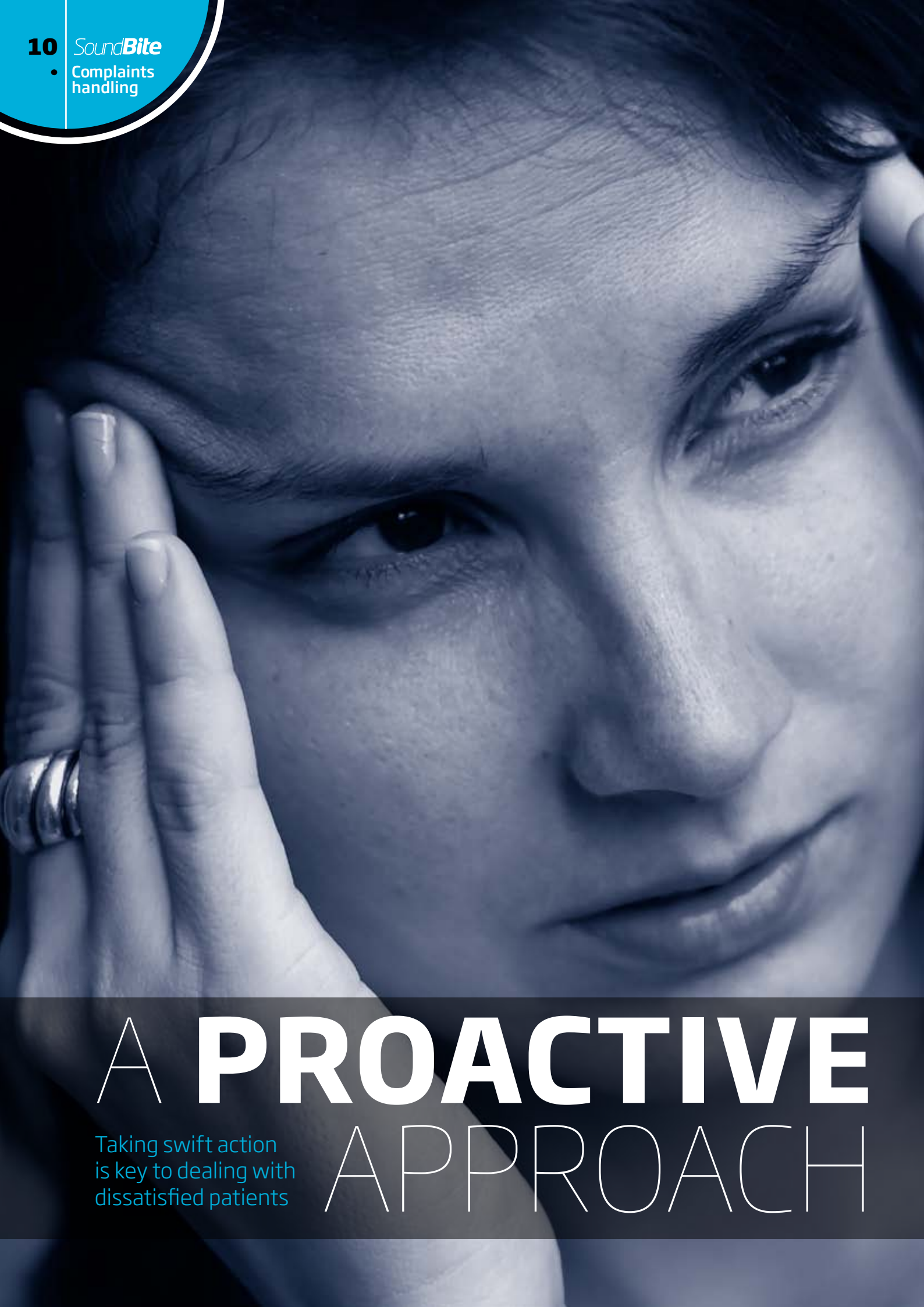
It is also frustrating sometimes not being able to provide more complex dental treatment for people who are unable to cooperate due to dental phobia or disability.

• What unique challenges do special care dental patients pose?
We have to be quite ingenious sometimes in working out the best treatment plan for patients and also how to provide care. I treat patients under general anaesthesia and sometimes the challenge is getting the patient into the anaesthetic room and asleep before we can even examine them. I am quite inventive with administration of premedication. You have to be flexible and adaptable - things don't always go to plan.

• Have you been surprised by any aspect of the job?
I think the biggest surprise is that I have got to know my patients very well and have a large group that I see on a regular basis. Unlike many hospital consultants we see our patients for recall and over the years I have got to know my patients and their parents/carers. It is very rewarding when I get a hug from someone who is pleased to see me.

• What advice would you give to a trainee considering special care dentistry?
I think my advice to anyone thinking about becoming a special care dentist would be to get some experience of special care. It is only when you meet a patient who refuses to let you examine them due to anxiety or a learning disability that you really understand the challenges faced by this specialty.

• What is your most memorable experience so far in the specialty?
I think some of the individual people and patients that I have met. I am amazed by the patience of parents of adults with learning disabilities, where every single day is a challenge. This has made me appreciate some of the difficulties people have in accessing dental care, how lucky I am and it enriches my life knowing these patients.



A PROACTIVE APPROACH

Taking swift action is key to dealing with dissatisfied patients

NO ONE likes being on the receiving end of a patient complaint but it is something that will most likely happen at some point in your career. As a newly qualified dentist starting out in practice, the best approach to take when this happens is a proactive one which involves communicating effectively with the patient and maintaining high professional standards.

"If a patient's expectations don't match yours, often it's the result of a failure to communicate"

And while it may be tempting to put off thinking about a complaint until another day, it is important to always respond quickly and carefully as this can often defuse the situation and prevent it from getting out of hand.

Patient complaints are among the most common reasons dentists contact MDDUS for advice. Cases vary but evidence has shown that the manner in which a dentist initially deals with a patient query/complaint greatly influences the process and outcome.

This is clear in one recent case that centres around payment for treatment. In this instance, a patient asked her practice why she was being billed for two consultations instead of one because she believed the second visit was a continuation of treatment initiated in the first visit. This simple query soon escalated into a complaint amid accusations that the dentist behaved aggressively and failed to provide details of the practice complaints procedure when asked. The dentist also made matters worse by accusing the patient of being unwilling to pay for her treatment and suggesting she apologise to him.

The case was brought before the Ombudsman and the dentist was criticised for his handling of the complaint. Had the dentist simply listened to the patient's concerns, explained why she was billed twice and provided any requested information, it would likely have gone no further.

So by following a few basic guidelines, you can help minimise the risk of complaints escalating into more serious matters.

A welcome ear

The importance of good communication skills in handling complaints – and also preventing them – cannot be underestimated. The General Dental Council's guidance *Principles of Complaints Handling* advises: "Many complaints will not be about your technical skills or the quality of the clinical care you give to patients. Patients complain because their expectations of a good level of service have not been met. If a patient's expectation does not match yours, this can often be the result of a failure to communicate."

If you receive a complaint, more often than not it can be dealt with on the spot with an honest and direct explanation and apology (where appropriate). Giving patients time to explain their concerns, and listening to them without interrupting, can be enough to defuse the situation.

Active listening is key. It's important to acknowledge the problem and invite the patient to air their concerns by saying something like: "I can see that this is a very serious issue for you. I am very sorry that this has not worked out as we both hoped. Please take your time and tell me what the problems are and then we can talk about how we can set them right."

It's important not to react defensively to complaints – patients have the right to ask questions, query treatment or raise general concerns. Dissatisfied patients can be fearful, mistrustful and angry; it's important to defuse and not further inflame such emotions. Try to acknowledge and understand the anger a patient may be feeling – and don't take it personally. It's important to remain calm and courteous.

Active listening also involves summarising what the patient has been telling you and validating their concerns. For example: "Let me check I have understood you correctly; you are concerned that there may be some further infection in your tooth. I can understand that this would be very worrying."

Saying sorry

Patients who complain are often just looking for a sincere apology and reassurance that a similar incident will not happen again to other patients. An obvious fear among healthcare professionals is that an apology may be interpreted as an admission of liability in any potential litigation.

But under the Compensation Act 2006, which applies in England and Wales, "An apology, offer of treatment or other redress, shall not of itself amount to an admission of negligence or breach of statutory duty." And guidance from the Scottish Public Services Ombudsman advises that an apology "is not a sign of weakness or an invitation to be sued", adding: "To apologise is good practice and is an important part of effectively managing complaints."

Each patient complaint is different so advice will vary depending on circumstances but there can be no harm in a sincere expression of regret for the patient's dissatisfaction. If in doubt, then seek advice from a senior colleague or from MDDUS for help with specific incidents.

Early warning signs

An important element of defusing complaints is in identifying them at an early stage. These can often start out as "comments" or "queries" or "suggestions". For this reason, it is important to avoid being dismissive or insensitive towards such patient contacts as this in itself might lead to the complaint escalating. As always, you should be familiar with the GDC's guidance *Standards for Dental Professionals* which sets out principles all dentists must follow when treating patients. Clearly, conforming to these standards of respecting patients, putting their interests first and maintaining your professional knowledge and competence will help to minimise the risk of patient complaints.

In addition, all dental practices should have a comprehensive policy in place for handling complaints that patients should be made aware of. Equally, dentists working in secondary care should be familiar with the health board/Trust complaints policy and advise patients where appropriate.

The GDC advises dentists to keep a written log of complaints "so that you can use this to monitor your performance in handling complaints and identify possible areas for improvement."

A recent report from the Dental Complaints Service, which helps private dental patients, provides an insight into some common reasons for complaints and also suggests complaints levels are rising among this patient group. Their latest figures show the number of complaints received increased by 24 per cent last year, rising from 1,180 in 2009/10 to 1,559 in 2010/11. Of these, 67 per cent were resolved within a week.

By far the most common reason for non-clinical complaints was failure of treatment (862 complaints last year) followed by patients complaining they were uninformed (158) and post-operative pain (121). The most common clinical complaints related to crown treatments (239) followed by root canal (142) and bridge work (126).

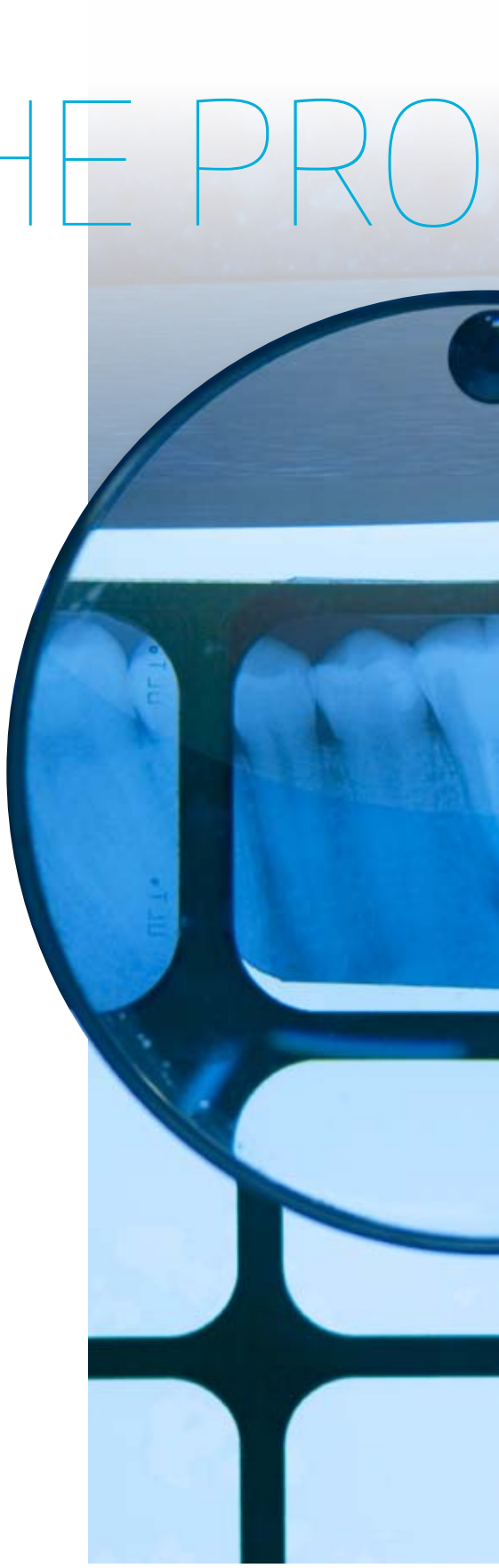
However, the DCS emphasised that most complaints can be resolved "quickly and amicably" by working with patients and professionals.

Standards for Dental Professionals neatly summarises the GDC's advice by saying: "Give patients who make a complaint about the care or treatment they have received a helpful response at the appropriate time.

"Respect the patient's right to complain. Make sure that there is an effective complaints procedure where you work and follow it at all times. Co-operate with any formal inquiry into the treatment of a patient."

Joanne Curran is associate editor of SoundBite

GETTING TO THE ROOT OF THE PRO



MDDUS dental adviser **Doug Hamilton** discusses some common clinical pitfalls in endodontics from a dento-legal perspective

Provision of endodontics is commonly required in order to secure dental health and relieve discomfort. Carried out efficiently and painlessly, it can provide the foundation for a functional dentition, build a relationship of trust between dentist and patient and contribute to the establishment of a successful practice. However, it is also technically difficult and failure can result in the onset of unpleasant symptoms, followed by loss of teeth and expensive restorations. In an age of growing patient expectation, poor endodontics can also lead to litigation and regulatory scrutiny.

Detailed guidance regarding endodontic techniques is beyond the scope of this article but I can offer some general advice which, if heeded, will help to minimise problems in this complex area.

Diagnosis

Dental practice can be busy and stressful – and if a patient with pain is 'squeezed in' there may be a temptation to provide relief by 'getting the pulp out' as quickly as possible. However, long before a size 10 reamer is picked up, key points must be addressed. For example, is the discomfort definitely of dental origin? If so, could this be relieved without root canal therapy? Answering these fundamental questions requires a careful history and examination.

Symptoms such as marked localised tenderness to pressure or pain which persists after thermal stimuli and/or disturbs sleep might well indicate a moribund pulp, in which case endodontics may be a reasonable treatment option. However, this diagnosis must be confirmed by thorough examination.

Locating the symptomatic tooth can be quite simple in some cases, for example in a complicated crown fracture or a lone-standing carious tooth. But acute pulpitis is notorious for presenting diffusely and when you are presented with heavily filled but otherwise unremarkable quadrants, locating the inflamed pulp can be time-consuming and difficult. Diagnostic aids such as ethyl chloride and percussion can be of great assistance in this process but cannot always be completely relied upon, particularly when treating the more anxious patient who may report pain in every tooth tested.

Radiographs can be helpful, particularly if the pulp has become moribund due to secondary caries or a particularly deep restoration but there will still be occasions where a definitive diagnosis simply cannot be reached. In these cases, treatment should be delayed until symptoms localise or a second opinion can be obtained.

Assessment

In most instances it will be possible to confirm the source of the patient's problem. However, even if it seems likely that endodontics will be curative, that size 10 file must still remain untouched until other aspects of the case are considered. For example, is the tooth in question restorable? There is very little point in completing the most beautiful canal filling only for the final restoration to fail catastrophically at an early stage.

Did the radiographs reveal potential complicating factors, such as bifid roots or calcifications? The presence of anatomical anomalies such as these might contra-indicate root canal therapy or require the assistance of a specialist. Factors such as the prospects of a successful endodontic completion and a stable coronal restoration must be properly assessed before recommendations can be made to the patient.

Consent

Informed consent must also be secured and in endodontics should include advice regarding alternatives such as extraction, as well as a description of the proposed procedure together with possible risks such as post-operative discomfort and infection recurrence.

BLEM

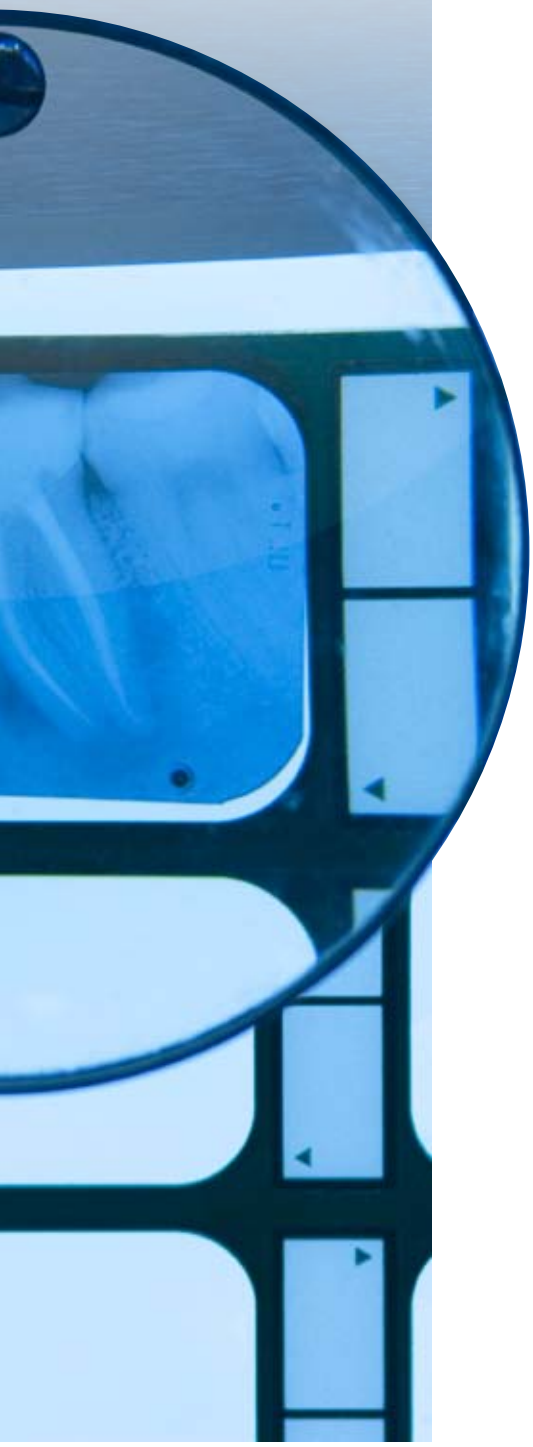


PHOTO: CHRIS KNAPTON/SCIENCE PHOTO LIBRARY

Advice regarding cost is also required. A written estimate is mandatory for all NHS patients, regardless of whether the endodontics is to be carried out privately. Remember that NHS Terms of Service in Scotland do not permit the mixing of private and NHS treatment on a single tooth. An NHS patient considering private endodontics must be advised why this treatment is being offered outwith the NHS and provided with a cost estimate of any restoration.

Problems.....

Endodontics is fraught with potential complications and some can be indicative of a lack of care and attention by the dentist. For example, inhalation of an instrument will almost inevitably be the result of a failure to use rubber dam and not using an irrigation syringe with luer-lock attachment and side vents may contribute to the forcing of sodium hypochlorite into apical tissues. Offering a defence in such situations can be very difficult.

Other problems may be simply beyond your control, such as instrument failure. However, if a complication is not recognised, or if its occurrence and possible remedies are withheld from the patient, then the practitioner will be left in a very weak position. Thankfully, many endo-related problems involve less calamitous outcomes, such as recurrent pain or sinus.

Regardless of operator skill and experience, not all root treatments will be successful and this need not be the result of poor technique. However, they ought to be a matter of regret and the ethical dentist will always endeavour to reassure the patient and remedy the situation, perhaps by offering repeat treatment or referral to a specialist. Unfortunately, there will still be circumstances in which complaints or even litigation may follow.

Just how successfully such cases can be defended depends on a number of factors. Pre-op assessment, treatment planning and reliable consent are important but the most common line of criticism with regards to failed endodontics is the quality of the final root filling. Problems can occur even with the most perfect canal obturation. In cases where the canal filling appears deficient, there may be a perfectly reasonable explanation for this which was accepted by the patient before treatment commenced. The sad truth is, however, that post-operative films showing obturation of a poor standard are often an accurate indicator of a lack of care in shaping and filling the canals.

Excuses for poor work based upon commercial and time constraints simply will not suffice. Painstaking canal preparation, assisted by appropriate radiographs to establish the working lengths (or, at the very least, use of an apex locator) and followed by a film which records a good final obturation are essential. Clearly, adherence to this regimen will maximise the chance of a successful treatment and stress-free day and demonstrate an adequate standard of care should problems later arise.

One final medico-legal requirement underpinning all of the above is record keeping. No matter how comprehensive the consenting process or how carefully the working length was measured, without evidence of these processes in contemporaneous legible notes your defence in any subsequent complaint or a claim will be limited. It is critical that each stage of the treatment, from the initial history to post-operative instructions, is clearly recorded for future reference.

Conclusion

Endodontic technique must be learned in the first instance from teaching staff and experienced colleagues and perfected by subsequent repetition, while always keeping up with new developments. Reference to the general guidelines discussed above should help avoid complaints and litigation. However, if problems do occur, please seek advice from MDDUS at an early stage.

Case study

Patient A attends the practice of dentist B complaining of broken down lower right premolars. Consent is obtained for root canal treatment followed by crowns. However, after completion of endodontics, the patient decides, for commercial reasons, to source the crowns in Eastern Europe. Patient A is subsequently examined by an overseas dentist, who declines to provide crowns because the root fillings are well short of the radiographic apices and poorly condensed.

On returning to the UK, the patient writes to dentist B requesting compensation. Refund of all treatment fees is provided but further remuneration to cover travel expenses is considered inappropriate. Patient A accepts the proffered compensation but then writes to the GDC, whose subsequent investigation focuses not only on the deficient obturations but also on the absence of any record that final X-rays were taken and checked. No defence can be put forward to these allegations and dentist B receives a written warning from the GDC.

Doug Hamilton is a dental adviser at MDDUS

WAS THAT UL5 OR...

This fictional scenario is based in part on a real case in which a trainee dentist removed the wrong tooth

DAY ONE

A patient contacts the surgery to make an appointment with his regular dentist – Mr T. A tooth is causing him considerable pain and he asks to be fitted in that day if possible. The receptionist informs the patient that there is no appointment available for Mr T but that he can see Mr V who is working as a VDP at the practice.

Later an appointment does become available with Mr T at an earlier slot so the receptionist cancels the appointment with Mr V but neglects to inform the patient, who turns up later to find he now has no appointment. He is annoyed and distressed as the tooth is very painful. Fortunately Mr V has had a DNA and is able to see the patient.

The patient complains that the pain is in the upper left quadrant and Mr V examines UL5 and finds it very tender on percussion. The tooth has a large restoration and Grade 1 mobility. The adjacent tooth UL4 is also slightly tender but UL6 is fine.

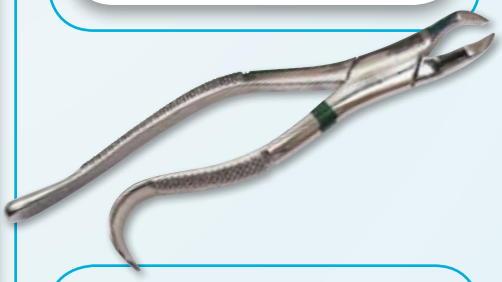
Mr V diagnoses irreversible pulpitis in UL5. The patient is adamant that he wants the tooth extracted as the pain is "unbearable". Confirming the patient's consent the dentist administers a local anaesthetic and extracts the tooth. Post-operative instructions are given to the patient who leaves satisfied.

An hour later the patient returns to the surgery and complains to the receptionist that he is now convinced that the wrong tooth has been extracted.

Mr V sees the patient again immediately and also summons the senior partner in the practice. The senior dentist reassures the patient that Mr V has extracted the tooth he believes was causing the pain. He arranges for the patient to return for a review appointment.

DAY TWO

The patient returns to the surgery now complaining of sharp pain in the remaining UL4. His regular dentist Mr T finds it to be moderately tender to percussion and extracts the tooth. A review appointment to discuss the provision of a denture is arranged.



DAY TWELVE

In his reply to the patient's letter Mr V states again it was his clinical opinion that UL5 had irreversible pulpitis and required extraction to which the patient agreed. The subsequent extraction of UL4 had no bearing on his diagnosis and treatment. He apologises for the distress caused to the patient.

DAY TEN

A letter of complaint arrives at the practice from the patient expressing anger over his treatment. He states that the tooth which should have been removed on Day One - UL4 - had been the subject of ongoing treatment with his regular dentist Mr T. A few months previous he had attended for the removal of a fractured cusp with the remainder of the tooth being filled. A few weeks later the tooth grew painful and Mr T prescribed an antibiotic and suggested it may need to be extracted. This was the state of affairs when the patient attended Mr V.

The patient also disputes the contention that he spoke to Mr V simply of pain in his upper jaw – but rather he states that he pointed out with his finger the "offending tooth". He states that the tenderness he felt with "tapping" on UL5 was simply due to its close proximity with the infected UL4. He expresses surprise that his dental records would not provide Mr V a clear indication of the tooth under ongoing treatment and wonders if the dentist had even consulted the records prior to the examination and treatment.

TWO months later another letter arrives from the patient in which he states his intention to contact a solicitor in regard to the "negligent treatment" he received by Mr V. Mr T contacts MDDUS for advice and in discussion it is agreed that there is no denying that Mr V extracted the wrong tooth and that nothing can mitigate the fact that the problems with UL4 had been clearly documented in the patient notes.

To remedy the complaint the practice partners agree to refer the patient for restorative treatment. A single implant is placed with a cantilever bridge restoration and the patient is satisfied with the final result.

Key points

- Ensure a fail safe system in all planned tooth extractions.
- Use a single form of tooth notation in all treatment to ensure there is no confusion.
- Double check the patient's clinical notes and radiographs before extraction.
- Ask the patient to state which tooth they believe is being treated and cross-reference with written notes.

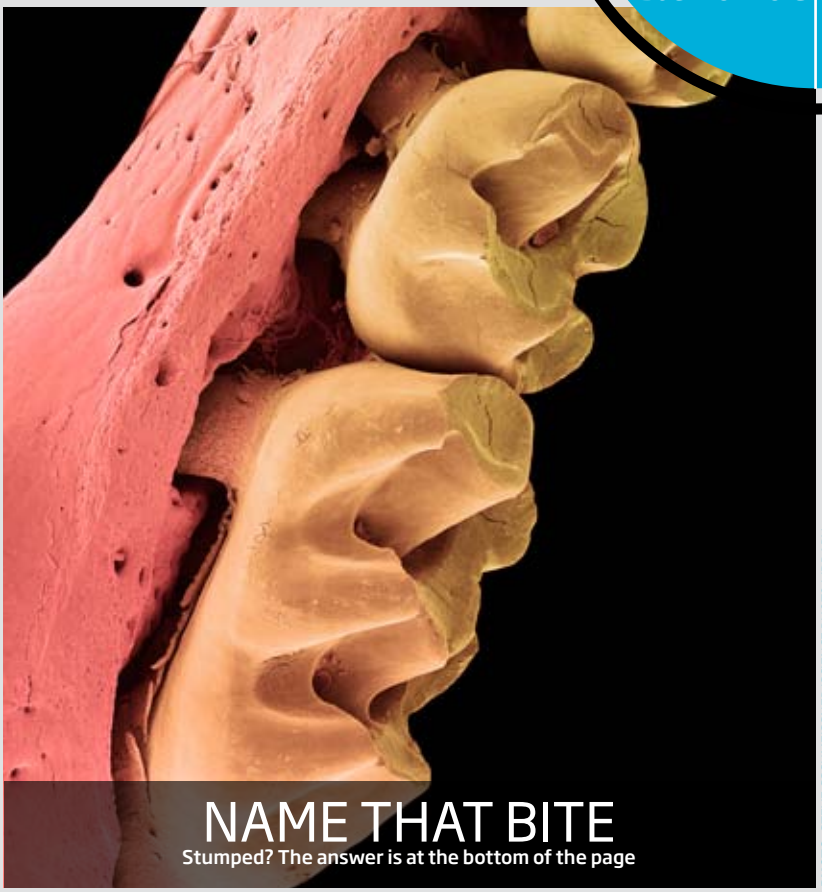
OUT THERE

ANCIENT TEETH A pair of beaver teeth found in northeast Oregon, US, have been dated at up to 7.3million years old, according to Associated Press. The teeth are said to be almost identical to living beaver teeth, showing that the animal has changed little.

BOOZY INCENTIVE Texas-based US dentist Clint Herzog has taken a unique approach to encouraging patients to attend – free beer and wine while they wait. He says the unorthodox approach has proved a hit with nervous types who say it helps them relax before appointments. *Source: Daily Mail*

SOUNDBITE An unusual hearing aid that transmits sound via the teeth has been approved for use in Europe, *Dentistry* reveals. The removable, non-surgical 'Soundbite' hearing system consists of a small microphone worn behind the ear and a retainer-like device that attaches to the teeth.

BYE BYE FILLINGS Scientists at Sheffield Uni have discovered pufferfish teeth regenerate every two weeks and believe their unique beak could hold the key to continuous tooth replacement in humans.



NAME THAT BITE

Stumped? The answer is at the bottom of the page

PHOTO: STEVE GSCHMEISSNER/SCIENCE PHOTO LIBRARY

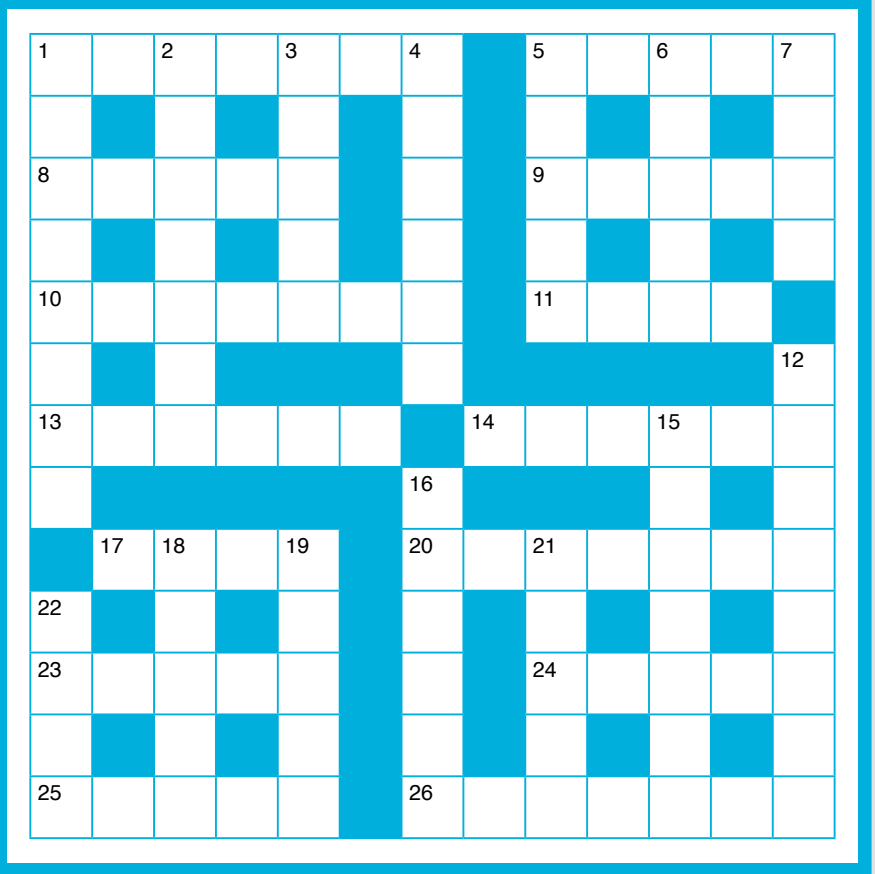
CROSSWORD

ACROSS

1 Brand name luting cement (7)
5 Orthodontic device (5)
8 Brand name temporary filling (5)
9 Cavity or sac (5)
10 Collection of pus formed in cavity (7)
11 Closed sac (4)
13 Of the midline (6)
14 Thin layer of restorative material (6)
17 Long-legged wading bird (4)
20 Root device (7)
23 Cable-like bundle of axons (5)
24 Brand name cement (5)
25 Hygiene procedure (shorthand) (1,3,1)
26 Of the palate (7)

DOWN

1 Orates (7)
2 Modifies (7)
3 Supple (5)
4 Practice of going naked (6)
5 Fundamental (5)
6 Pre-decimal Indian coins (5)
7 The Orient (4)
12 Honest (8)
15 Shoulder ornament (7)
16 First class (3)
18 Nobleman (5)
19 Broom use (5)
21 Student (5)
22 Collection of wildebeest (4)



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

NAME THAT BITE: SEM of mouse molars

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