

ALSO INSIDE









Welcome to your SoundBite

Many dento-legal cases can be boiled down to a handful of basic errors and omissions - or sloppy habits, says Claire Renton. And on page 10 of this issue she offers a quick overview of some of the most common encountered in her role as a dental adviser at MDDUS. It makes worthwhile reading for dentists at any stage.

In a similar vein, dental ethicist Dick Birkin looks at how "bending the rules" to a save bit of time or money can be a slippery slope to professional difficulties. On page 5 he champions the view of CS Lewis that ethics can be defined as "Doing the right thing even when no one is watching".

Have you ever wondered how your skills as a dentist might be used to make a real impact in the lives of people in desperate need? On page 6 dentist Hari Lal tells how he travelled to a deprived region of Kenya where over half the patients he saw

didn't even own a toothbrush. The experience tested him in many ways but in the end was nothing less than a "privilege".

Periodontitis is an insidious condition in which bleeding gums may be the only obvious marker - not something many patients tend to get overly worried about. Yet the consequences of such "supervised neglect" can be costly for both patient and dentist. One page 12 dental adviser Doug Hamilton looks at some common pitfalls in dealing with the condition - and the topic is followed up in our case study on page 14.

It used to be that dentists interested in specialising in oral medicine faced the daunting prospect of a second degree in medicine. Not any more - though the specialty is no less competitive. Learn more in our careers article on page 8.

 Martin Nimmo Editor

WARNING OVER POTENTIAL **JOBS SHORTAGE**

ACTION must be taken by the Department of Health to avert a potential shortage of training places for 2013 dental graduates.

The British Dental Association issued the warning after new figures predicted a shortfall in training places next year.

The UK Committee of Postgraduate Dental Deans and Directors (COPDEND) confirmed 1,139 applicants will be competing for an estimated 952 funded places in NHS practices. Of the applicants, 1,026 are current students or recent graduates from UK dental schools.

Judith Husband, chair of the BDA's Ethics, Education and Dental Committee, said the COPDEND figures raise the prospect of "another year of heartbreak" for dental students as well as being a waste of public

She added: "The Department of Health must... act now to ensure that 2013 does not see a repeat of the senseless situation that has been witnessed this year."

The DoH admitted that 35 UK graduates were not allocated training places in 2012, each having cost taxpayers around £150,000 to train.

UK DENTAL CARE HIGHLY RATED BY PATIENTS

DENTAL treatment in the UK is well-explained, provides value for money and delivers high levels of satisfaction among patients, according to a

A survey of 1,000 people found eight out of 10 who had seen a dentist in the previous two years were highly satisfied with their treatment. And almost eight out of 10 of those who paid for treatment thought the explanation of fees and charges was "good" or "very good" with more than three-quarters rating their treatment as "good" or "very good" value for money.

The figures were revealed in Public perceptions of choice in UK dental care, commissioned by the British Dental Association.

Of those surveyed, four out of five had visited their dentist in the previous 24 months while around one in 15 said they never visited a dentist. The most common reason for not visiting the dentist, particularly among men and the over-25s, was that it was not felt to be necessary.



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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 2012) 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 February 28, 2013.

BDA CALLS FOR ACTION ON TOOTH WHITENING



THE British Dental Association is calling on dentists, Trading Standards officials and the GDC to join forces to put an end to teeth whitening treatments being supplied illegally by non-qualified individuals.

The European Council's *Directive on Tooth Whitening Products* came into effect on October 31 and means products containing up to 0.1 per cent of hydrogen peroxide will continue to be freely available to consumers on the market.

However, for products containing between 0.1 per cent and six per cent of hydrogen peroxide, a clinical examination and treatment plan by a dentist is required. The first cycle of treatment must be carried out by a dentist or an appropriately trained individual working under their direct supervision and within

their competence and scope of practice. Detailed, accurate and contemporaneous notes are an essential requirement of this first visit. Patients will then be able to continue the treatment unsupervised, although the use of these products by persons younger than 18 years will not be allowed.

Tooth whitening products containing more than six per cent of hydrogen peroxide will continue to be prohibited.

The BDA is concerned that some individuals might choose to ignore the directive and is calling on dentists to report non-dentists offering tooth whitening to both their local Trading Standards department and to the GDC, and for both agencies to take robust action in response to such reports.

BE ALERT FOR ORAL CANCER

FAILURE to spot intraoral malignancy can have serious repercussions for patients – and also dentists, says MDDUS dental adviser Rachael Bell.

Mouth Cancer Action Month was held in November to raise awareness and improve understanding of oral cancer among both the public and the profession. MDDUS is reminding dentists of the crucial role they play in the early detection of the disease through routine screening and educating patients on the risks and warning signs.

The British Dental Health Foundation (BDHF) estimates that over the next decade around 60,000 people in the UK will be diagnosed with mouth cancer and without early detection half will die. Cases involving failure to diagnose and refer patients with oral cancer feature regularly among clinical negligence claims made against MDDUS members and in GDC fitness to practise investigations.

Proper examination and good record keeping are essential. Says Bell: "The only defence to a claim made following delayed diagnosis is if adequate examination of the patient was made, backed up with proper notes in the dental record.

"Unfortunately, we are still seeing dental records that amount to 'Exam SP', with no mention made of how an examination was carried out and what was examined or found."

MDDUS recommends that all practitioners follow current recommendations with regard to examination and dental records, such as those set out in the FGDP(UK) book, *Clinical Examination and Record Keeping*.

Says Bell: "Where there is an allegation of failure to diagnose an oral malignancy, we would be looking for notes in the records of an extra-oral examination, soft tissues being examined and the findings – even if the findings are that the tissues are healthy. The notes also need to reflect whether smoking cessation and alcohol-related advice has been given and what was said. If there is any doubt about an intraoral lesion then refer early, keep a copy of any referral letter and any response from maxillofacial services."

RISE IN COMPLAINTS ABOUT PRIVATE DENTISTS

THE number of complaints made about private dental treatment rose by 17 per cent last year, new figures show.

A report from the Dental Complaints Service (DCS) revealed it dealt with 1,887 complaints in the year to April 2012, compared to 1,559 complaints the previous year. The DCS' Annual Review 2011-12 also showed the service received 14,145 calls compared to 13,522 in 2010-11, a rise of 4.5 per cent.

The most frequent concerns related to patients feeling they were not properly informed about treatment, being given unclear information and feeling their concerns were ignored. The top treatment types for complaints were crown (16 per cent), full and partial denture (15 per cent), filling (14 per cent), root canal (nine per cent) and implant (nine per cent).

However, two-thirds of complaints were resolved within a week with many cases resulting in remedial treatment, a refund, an apology or an explanation. The DCS, now in its sixth year, is a free service funded by the General Dental Council to deal with complaints about private dental care.

Read the *Dental Complaints Service Annual Review* 2011-12 at www.tinyurl.com/b73rchx



LISON is two months into her dental vocational training. One night, she is driving home from work and takes an alternative route to avoid roadworks. She momentarily takes her eyes off the road to check her rear view mirror just as the road turns sharply to the left. Her car drifts over the centre line, clipping an oncoming vehicle.

No one is hurt in the accident but Alison is later convicted under Section 3 (careless driving) of the Road Traffic Act. She is issued with a fine and her licence is endorsed. A few months later she is shocked to receive a letter from the General Dental Council. Her conviction has been reported by the police and she has now been contacted to provide her "observations" on the incident to a GDC investigating committee. Failure to do so could result in suspension from the dental register.

Where does Alison stand regarding legal advice in this case? For any dentist who finds themselves in such a scenario, it depends entirely on whether or not you have appropriate indemnity cover. If you have failed to arrange such cover then the cost of appointing legal representation for a possible appearance at a GDC fitness to practise hearing could run into thousands of pounds and be a very stressful experience.

Fortunately for Alison she was a member of MDDUS at the time of the car crash and she was able to access support and advice to guide her safely through the GDC procedures.

This scenario is based on a real case at MDDUS and demonstrates why membership of a dental defence organisation (DDO) should not be considered as an optional extra for dental trainees.

MDDUS is an independent 'mutual' DDO. General dental practitioners pay an annual subscription fee and in return receive access to appropriate legal representation and indemnity for damages and costs arising from judicial decisions or out-of-court settlements in clinical negligence cases. In addition MDDUS provides GDP members access to appropriate legal representation and support in GDC proceedings and in other professional matters. Hospital dentists employed by the NHS will be covered by Crown indemnity for clinical negligence but not for legal support in GDC matters, and for this reason many also belong to a DDO. All MDDUS dental members also enjoy access to a 24/7 telephone advisory service staffed by qualified dentists with expertise in dento-legal matters.

Most dental students will join at least one DDO or sometimes more if only just for the freebies handed out. But some may let that membership lapse once they graduate, perhaps in a bid to save money or maybe just

through inaction. This is a serious error.

Those working in general dental practice are required by the GDC to have appropriate indemnity/insurance so that patients can claim any compensation they may be entitled to. The GDC recently issued an advice notice to patients urging them to check their dentist/dental care professional is properly insured or indemnified for the treatment they are carrying out. The regulator also advised patients how to make a complaint and to contact the GDC "if you think the dental professional treating you is a risk to other patients."

MDDUS advises dentists to ensure they are fully compliant so they can meet their patients' expectations and needs, as well as looking after themselves.

Under new government plans, the need for appropriate

"Those working in general dental practice are required by the GDC to have appropriate indemnity"

indemnity/insurance is expected to soon become a statutory requirement, meaning all healthcare professionals will be legally obliged to have the cover as a condition of their registration.

Failure to arrange appropriate indemnity cover could have serious consequences. A dentist from Glasgow hit the headlines in June when he was struck off by the GDC for operating without indemnity/insurance for almost 20 years. He argued that he had made his own arrangements to cover anything going wrong and that any claims would have limited value because of the field of dentistry in which he

This was rejected by the GDC who said in their judgment: "Unexpected and severe complications can arise during the most basic of treatments which could have a great impact and involve unpredictable consequences. You were no different from any other general dental practice in terms of that risk and it is of great concern to this committee that you did not recognise this." The dentist was banned from practising for at least five years.

So ensure you are fully protected today - and if in any doubt call the MDDUS membership line on 0845 270 2038.

Joanne Curran is associate editor of SoundBite



RECENT English court case highlighted dentistry's need for probity and honesty. The dentist involved was criticised by the judge who, in jailing her for six and a half years, described her actions as "calculated, blatant and persistent dishonesty". The jury heard how she had submitted claims for treating more than 100 patients who were dead and made duplicate claims for others. Investigators from NHS Protect said she had forged more than 28,000 documents to support her "bogus claims". An extreme example and luckily a very rare one.

Dentists not only need to behave honestly; like Caesar's wife they have to be above suspicion. The public trust and look up to dentists. The other side of the coin is they expect us to behave differently. We are expected to put patients first and not be influenced by the needs of our bank manager. However, the slippery slope to court or the General Dental Council is one which is all too easy to follow if we are not careful.

The damage of high-profile court cases is not just to the individual but also to the profession itself. Each such case or journalistic exposé gradually erodes public trust in dentists. If this was to become widespread we move from being a profession to being a trade. Retaining that trust is vital.

There are many temptations in general practice. The pressures of running a business are considerable. On many occasions your business head will be in conflict with your professional self. It is easy to justify "bending the rules". We complain of the government or the Department of Health treating us unjustly through low fees or poor pay rises. The temptation is to redress the balance, to "game" or to "pad" claims. No one gets hurt, do they? If

successful the temptation is to do more, leading us ever more quickly down that slippery slope.

"Doing the right thing even when no one is watching" (to quote CS Lewis) is a succinct practical definition of "ethical". Certainly as a dentist for much of the time you will not be being watched. You are trusted to behave honestly. There will be no lecturer, VDP/FD trainer or DRO looking over your shoulder.

There are of course many grey areas both ethically and legally in the practice of dentistry. For example, do you discuss all treatment options whether or not you make money from them? Do you use unbalanced advertising material? Is your tone and body language unbiased when discussing options? Do you always give a written treatment plan with costs? Do you inform patients that nearly 20 per cent of crowned teeth become non-vital within five years and that veneers remove between nine and 30 per cent of the tooth? Or, as a recent Which? investigation reported, do you only give the hard sell for tooth whitening? It is easy to let financial pressures influence your discussions with patients in the consent process.

It is even easier to "misinterpret" regulations. One of the oldest grey areas is the claiming of fees for sealant restorations (preventive resin restorations). In both Scotland and England there is an increased fee associated with these restorations.

The fundamental difference between the two is the diagnosis, and the treatment, of caries. Clinically they appear the same. Only you, your dental nurse and possibly the patient know what was actually done. Your decision on what fee to claim is down to your ethics. And who will know? The answer is – you will, and

you will have to live with it. It is easy to think that if it worked once, why not do it again?

There are many other grey areas: misleading patients as to what is available on the NHS, changing dates on record cards to avoid time bars, splitting courses of treatment to avoid prior approval or to increase the UDAs claimed, or carrying out one visit periodontal treatments and claiming increased fees.

It is all too easy to think that no one will notice or check, or that "everyone does it". Dentists are trusted to put patients first and claim appropriately. However, this trust only goes so far. There are deterrents. Your claiming patterns will be monitored statistically and compared to others in the same health board/ Trust or even street. Your record cards can be reviewed for the record of what and how you treated the patient. In the sealant restoration example, did you chart the decay? What materials did you use? Did you use local anaesthetic? Did you carry out an enamel biopsy? What does your nurse think about what you are doing? Dental care professionals have an ethical duty to whistleblow.

Meanwhile in Scotland a counter fraud charter has been signed by the BDA and NHS Counter Fraud Services which is designed to combat fraud and promote ethical conduct.

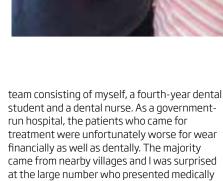
The vast majority of dentists are honest, ethical and empathise with their patient. Do not forget to do the right thing "even when no one is watching" because it is easier than you think to slide down the slippery slope to professional difficulties.

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



Dentist Hari Lal talks about helping deprived children and learning Swahili on an eventful trip to Kenya

MISSION



N a normal day's dental work it's fair to say that getting up close to a giraffe and speaking Swahili do not feature prominently. But these are just two of the unique experiences I encountered when I took a month off work to volunteer in Kenya.

I have always believed that helping those in need is one of the most important things in life and I was keen to do something that could also make use of my skills as a dentist. It was this thought that prompted me to contact the coordinator of Gracepatt Ecotours Kenya, Patrick Karimi (who runs the company with his wife Grace) to find out more about their dental internship project. And, after hearing about the poor state of dental care in the deprived area of Malindi, I decided I wanted to help.

To prepare for my month-long trip into the unknown, I spent a few weeks gathering up as many dental supplies as I could. I was taken aback by the generosity of companies such as Wright Cottrell, Colgate, Oral B and others who kindly donated items including gloves, masks, visors, filling material, disinfectant wipes, toothpaste, toothbrushes and scrubs, as well as toys and stickers for children.

With everything I'd need carefully packaged, it was finally time to set off for Kenya. I arrived in Nairobi off an almost nine-hour flight to be warmly greeted by Patrick who took me to a transit house for the night where I hoped I'd shake off any jet lag. The following day he took me to the Sheldrick elephant orphanage and a giraffe centre where we had the chance to see

these beautiful animals up close. It certainly made for an unusual and enjoyable introduction to Africa.

From there, it was time to go to work and a rather hot and bumpy seven hour bus ride took me to the town of Malindi on the country's south-east coast. On the bus I met hospital coordinator George Mumba who took me to meet the family whose home I'd be sharing for the next month. Staying in a traditional African

"Around half the patients didn't own a toothbrush, never mind regularly brushing."

home really added to my experience with my friendly hosts introducing me to traditional African food and culture, as well as teaching me some basic Swahili.

Once I'd settled in it was time to go to the hospital dental clinic where my adventure really began.

Deprivation

I was given a position within the Malindi District Dental Department leading a small with HIV.

The prime treatment we carried out was extractions - sometimes multiple in the same patient - and there were several patients with facial trauma seen in other departments who presented for dental review. More unusual tasks included providing treatment for prisoners or carrying out age assessments for patients involved in court cases.

Unfortunately, facilities in the clinic were limited. In addition to the dental chair being broken and the drill being inoperable, there was a lack of instruments, gloves and masks. The sweltering heat only added to the challenging environment. Despite the difficulties, I knew this was the best it was going to get thanks to the financial restrictions placed on the hospital by its limited government funding.

Each morning, at least 10 patients would queue outside the clinic waiting to be seen, mostly complaining of toothache that had kept them up all night. Around half the patients didn't even own a toothbrush, never mind regularly brushing. The dental student, Steve, acted as my interpreter as very few patients spoke English. I had learnt the basics in Swahili and could say things like open wide, extractions,







Hari Lal treats patients at a clinic in Malindi District Hospital (opposite page and left) and raises awareness of oral health amona local schoolchildren

pain, numb, filling and bite together. Mornings were like a conveyor belt of patients but it was rewarding knowing they were leaving with the source of the pain removed.

Outreach

The afternoons in the clinic were quieter so I arranged to promote dental health in the community with Steve. We visited three local schools - Sir Ali Bin Salim, Malindi HGM and Malindi Central Primary school - speaking to

packed classes of 70 and 150 pupils, plus a whole school of 1,000 pupils aged 10 years or older.

With the aid of the blackboard, demonstration models, posters and Steve's language skills we covered topics including tooth structure, diet, brushing, fluoride, caries, periodontal disease and hand hygiene both in English and Swahili. The pupils seemed keen to learn and we guizzed them at the end, offering prizes and samples for those answering correctly.

these kinds of visits are, particularly as many villagers struggle to afford even basic dental supplies, but I was pleased to find out that several of the pupils we had spoken to visited Malindi District Hospital to get their teeth checked. During the school visits, community health workers listened and took notes with the aim of continuing to deliver dental health education to other schools. I am happy to report that two more schools have been visited by these dental health promoters in Malindi since I returned to the UK.

It can be difficult to know how effective

Looking back on it, the whole experience was a real challenge and took me out of my comfort zone of working in a fully equipped dental practice with patients who can understand English. Spending a month in such conditions has also really opened my eyes to the problems of government-run dentistry in Kenya and I would urge other dentists and dental students to consider volunteering. I have made some cracking new friends for life and had the privilege of helping patients in great need of treatment as well as helping to educate schoolchildren about the importance of prevention. The experience definitely enhanced my clinical skills and has given me a glimpse of the other face of dentistry.

- With thanks to Patrick and Grace Karimi

Hari Lal works as a dentist in Dedridge

Dental Centre, Livingstone

DENTAL VOLUNTEERING

Gracepatt Ecotours Kenya The tour and travel company operate medical/dental missions and internship programmes. They are looking for general volunteers as well as clinicians holding medical/dental qualifications. www.gracepattecotourskenya.org

Bridge2Aid

This UK dental charity was set up in 2002 and works to improve dental care and access to pain relief for the people of Tanzania. They have trained more than 160 local health workers in emergency dentistry and continue to train a further 50 per year. Through their Dental Volunteer Programme, qualified dental professionals travel to Tanzania to pass on their skills. www.bridge2aid.org/b2a/

Mercy Ships The UK charity operates a number of hospital ships, staffed by a volunteer crew, serving more than 150 ports in developing nations around the world. Their dental programme welcomes diseases and provide education and training for some of the world's most deprived populations. www. mercyships.org.uk/dental

Other useful links include: www.christianreliefuganda.org www.smiletrain.org www.dentaid.org www.dentalprojectperu.org www.kausaywasi.org www.fitfortravel.nhs.uk



Looking for a broad and challenging specialty at the interface of dentistry and medicine? Oral medicine might be for you

T'S surprising to consider just how much overall health is reflected in oral health. It has been estimated that 90 per cent of systemic diseases have oral manifestations be it mouth ulcers in Crohn's disease, angular cheilitis in iron deficiency or xerostomia in diabetes. Conversely, significant orofacial pain or disease has a profound effect on the wellbeing of any patient.

Oral medicine sits at the interface between dentistry and medicine and can be defined as a dental specialty "concerned with the oral healthcare of patients with chronic, recurrent and medically-related disorders of the oral and maxillofacial region, and with their diagnosis and non-surgical management."

Specialists practising oral medicine in the UK must qualify for inclusion on the Oral Medicine Specialist List maintained by the General Dental Council. To achieve a CCST (Certificate of Completion of Specialist Training) in Oral Medicine from the GDC requires a training programme normally of five years duration. This may be reduced for those who apply to the programme with additional qualifications such as a medical degree.

The job

Oral medicine is an out-patient specialty for the most part, with clinics involving referrals from primary dental and medical care. However, increasingly specialists are receiving referrals from other medical specialties in secondary care, including rheumatology, gastroenterology, dermatology, GU medicine, neurology and even psychiatry. An oral medicine specialist is therefore expected to be conversant with colleagues across these

specialties in the management and onward referral of patients.

Oral medicine specialists are often involved in teaching, as the subject is a core component of the undergraduate dental student curriculum in the UK. They also have an important role in delivering postgraduate education for professional examinations and CPD for practising dentists. Specialists in oral medicine are often in demand from postgraduate deaneries to deliver courses on facial pain, soft tissue disease and the management of medically compromised patients in general dental practice.

Oral medicine is one of the smallest dental specialties with 16 units across the UK, mainly based within dental teaching hospitals, and around 40 practising consultants. The consensus from the British Society for Oral Medicine is there should be one consultant in place for every one million of the population and the Society is actively working towards securing new posts and increasing trainee numbers.

Entry and training

Posts in oral medicine specialty training programmes in the UK can be few and far between and competition is keen. The basic entry requirement is two years of postgraduate foundation training in dentistry, including experience in primary and secondary care settings. A diploma of membership (MFDS) in a dental faculty of a Royal College is not essential but strongly recommended. Previously a second degree in medicine was required and trainees may still choose to pursue this route before entering specialty training.

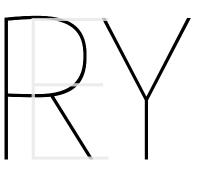
Training involves significant time spent in oral medicine outpatient clinics, seeing new and review patients under the supervision of a consultant. Trainees are encouraged to see hospital in-patient referrals on the wards and there is a notable overlap with the work of colleagues in special care dentistry in managing the most medically-complex patients. Experience of a hospital environment through oral and maxillofacial house jobs, while not essential, gives invaluable insight into the workings of a hospital and can be very useful to dentists aspiring to a training place in oral medicine.

Trainees are required to attend additional specialised out-patient clinics, such as dermatology, gastroenterology and rheumatology, and are encouraged to visit other oral medicine units. Another mandatory component of the curriculum is proficiency in soft tissue biopsies through a dedicated biopsy list.

A new development in specialty training for oral medicine has been the national Specialty Training Forum organised by the BSOM. The forum brings together trainers and trainees to gain experience with Work-Based Assessment tools in a safe supportive environment and aids preparation for both ARCP and ISFE (see later).

As with other specialties there are many opportunities to attend training events and meetings across a number of medical and dental specialties. Trainees should be active in presenting at interdepartmental and regional clinico-pathological case conferences to develop their skills in interpretation and conversing with colleagues in oral pathology.

Trainee specialists will be expected to





publish at least one paper during their training and this may take the form of basic science, translational research, clinical audit or case reports. Presentations at national and international meetings are encouraged and the BSOM offers prizes at undergraduate and junior trainee level.

A CCST in oral medicine is awarded by the GDC on the recommendation of the local postgraduate dental dean following evidence of satisfactory completion of the oral medicine curriculum and the Intercollegiate Specialty Fellowship Examination (ISFE) in Oral Medicine. Candidates must also achieve a successful outcome in the Annual Review of Competence Progression (ARCP) process as outlined in A Guide to Postgraduate Dental Specialty Training in the UK (Dental Gold Guide).

Most oral medicine specialists will work either in the NHS as a consultant or in an academic university post with an honorary consultant appointment. For more information on a career in oral medicine visit the website of the British Society for Oral Medicine (see below).

Dr Clare Marney, honorary specialty trainee in oral medicine, Glasgow Dental School, with Jim Killgore, publications editor, MDDUS

Sources Atkin P, et al. *Oral medicine*. BMJ Careers 2006 332:33.

The British Society for Oral Medicine website: www.bsom.org.uk

GDC. Specialty training curriculum for oral medicine. SAC in the Additional Dental Specialties. Access on the GDC website at www.gdc-uk.org



Q&ADr John Steele, specialty registrar/ honorary clinical lecturer in oral medicine

What attracted you to a career in oral medicine?

oral medicine?
During my dental undergraduate years in Glasgow I was most interested in oral medicine and pathology and the excellent department there fuelled my curiosity. Following VT, I took up an SHO post at Dundee Dental Hospital in oral medicine and pathology and this made me determined to pursue oral medicine as a career. With this in mind, I accepted a three-year post as lecturer in oral medicine in Liverpool. This gave me vast experience of the spectrum of oral medicine and also research opportunities. I then went to medical school in Birmingham and following this worked as a doctor for a few years back in Merseyside. I then started in my current post as a specialty registrar/honorary clinical lecturer in oral medicine in Liverpool.

 What do you enjoy most about the specialty?

specialty?
I enjoy the medical management of the numerous conditions that affect the oral and maxillofacial region. Oral medicine lies at the interface of dentistry and medicine and has crossover with a number of medical specialties including dermatology, gastroenterology, rheumatology, ophthalmology, infectious disease, haematology and psychiatry. Many cases can provide both a diagnostic and management challenge due to patients' co-morbidities and their polypharmacy. Also, after doing weeks of nights and weekends on call as a medical/surgical doctor and unsociable hours working in the emergency department, the nine-to-five regular hours of outpatient clinics are highly

Are there any downsides?

Oral medicine, as a distinct specialty, is practised currently by only 36 consultants based in dental hospitals.

This means that there are only 16 oral medicine departments in total in the whole of the UK and Ireland. This limits where a potential trainee could work.

 What have you found most challenging in your training?

in your training?
The financial ramifications of returning to medical school and therefore losing a regular income and associated pension contributions were challenging. However, the actual learning experience was invaluable.

 Have you been surprised by any aspect of your training?

Not really I know what to expect having.

Not really. I knew what to expect having worked in my current unit before and also having read the oral medicine curriculum in advance.

 What advice would you give to a dentist considering oral medicine? Now that studying medicine and being registered with the GMC is no longer a requirement to enter specialist training, I would advise dentists to seek SHO/ clinical teaching posts in the specialty to gain valuable experience/publications prior to applying for a specialty registrar position. I would also recommend joining the British Society for Oral Medicine (BSOM, www.bsom.org.uk) to keep abreast of clinical updates, specialty meetings and job opportunities.

What is your most memorable experience so far in the specialty? The most memorable experiences are the challenging, interesting and rare cases that present. It is also very rewarding to reassure a highly anxious patient that they do not have the life-threatening condition they were anticipating. Also, having recently passed my exit exam (ISFE) in oral medicine I do not have to sit another exam ever again!

Pros and cons of oral medicine



Pros

- Interesting, varied and intellectually stimulating
- Uses breadth of medical and dental training
- Generally no on-call requirements
- Clinical, learning and teaching, research, and administrative opportunities in either NHS or academia
- Scope for specialty expansion
- Starting consultant salary takes account of second clinical degree



Cons

- Long training
- High cost of training (but ability to locum)
- Exam fatique
- Availability of ST posts
- Geographic restrictions in UK and abroad

From Atkin, et al

SLIPPING SLIPPING

Dental training may have qualified you as fit to practise but have sloppy habits already crept in? MDDUS dental adviser **Claire Renton** looks at some to avoid

UTTING corners and taking shortcuts is something we are all probably a bit guilty of at some point in our lives, but on most occasions no harm is done. Anyone who has ever taken driving lessons, for example, will remember being taught to "feed the wheel", but how many drivers can honestly say we still do so once our test has faded from memory?

It is common to make judgements on what risks we are prepared to take by weighing up the likely benefits against any potential harm. But what happens if we start to cut corners in dentistry? What are the risks of deviating from our training when carrying out assessments or providing treatment for our patients?

There is no doubt that, over time, as our experience and ability increase this will inevitably lead to changes in our clinical practice. Occasionally however, these changes might not be made for the right reasons – i.e. to speed up treatments or increase profit – and this could lead to problems. Patients may be adversely affected, prompting complaints, and you could find yourself in professional difficulties with the General Dental Council if your clinical practice is not in line with their guidance.

At the root of many dento-legal cases dealt with by MDDUS are a handful of basic errors and omissions - or sloppy habits - that, if avoided, could have prevented a lot of trouble for our members.

Rubber dam

Top of the list when it comes to sloppy habits has to be not using rubber dam for root canal treatment. Can anyone remember doing an RCT at dental school without it? No, me neither! But what about now? Are all your root canal treatments still done under rubber dam? Have you ever been tempted to access a canal with a file without rubber dam? Some dentists don't bother using it because they

find it difficult to place and believe they can work just as effectively without it.

I am a great fan of rubber dam and find that once you get used to applying it (it's easier if you get your nurse to help) lots of types of dental treatment are so much easier. Root canal treatment is actually much simpler with rubber dam. It keeps slobbery wet tongues at bay and, by popping in a saliva ejector underneath, your nurse can concentrate on assisting you rather than aspirating every two seconds. Once you've cleaned and irrigated the canals they don't fill straight up with contaminated saliva and you've got half a chance of your treatment being successful.

Of course one of the most important functions of rubber dam is airway protection. There is simply no defence for an inhaled or swallowed file during root canal treatment performed with no rubber dam in place. Here at MDDUS we see a steady trickle of cases where endodontic instruments have been ingested because of a lack of rubber dam and it's always a stressful situation for all concerned.

The patient clearly has a serious medical problem if they have swallowed or inhaled an endodontic file and the dentist is in the awful position of explaining that the patient now has to make an urgent visit to hospital for assessment and possible surgery to retrieve the file. Not surprisingly, patients are not happy about this and often complain or raise a claim through solicitors.

Periodontal pitfalls

Another treatment that can fall victim to complacency is omitting to carry out a BPE (basic periodontal examination) for new patients and as part of regular check-up appointments which could lead to a failure to spot an emerging periodontal problem (see page 12). The BPE is a simple and quick way of checking the state of the patient's periodontal health and is an essential component of patient management. Claims for cases relating to undiagnosed periodontal problems usually run into thousands of pounds.



Retraction cord or equivalent material

Other slightly sloppy habits we can get into include failing to use retraction cord, or an equivalent, if needed during crown preparations with inevitable resultant poor margins and poor fit of restorations. This might not prove problematic for a year or two but patients are likely to remember how much they paid for their crowns and expect them to last.

Matrix bands

Wedging matrix bands is another technique that can often become a distant memory of dental school. This easy and quick method helps ensure a decent profile for restorations and stops your toes curling with embarrassment when you have to report on your bitewings and comment on that blob of amalgam clogging up the interproximal areas!

History

Don't forget to check medical histories at each appointment. It's really easy to get sloppy over this one but many patients have medical histories that need careful handling. It's at best embarrassing to be called by the local pharmacist to say you've prescribed penicillin to an allergic patient and at worst downright dangerous. And don't wait until you've extracted a couple of huge molars to discover that your patient is on warfarin or bisphosphonates.

Non-clinical issues

Not all problematic sloppy habits relate to clinical work. Other common causes of patient complaints concern the financial side of dentistry. It's an important requirement that

patients receive a treatment plan and an estimate of their treatment costs. Any estimate should be clear as to whether charges are for private or NHS work. Without a clear plan and estimate in place, there is scope for confusion or even disagreement once treatment is completed.

Dental records

Another recurring issue is dental record keeping. Indemnity organisations are always banging on about this, but it's true to say that if it's not in the records then the assumption is you didn't do it. Memories fade and the only way to be sure of what you did and didn't do is to write it down. Don't get sloppy with your records – take a note of what you discussed with the patient, particularly if the treatment is complex or expensive; record the options you discussed and record what warnings you have given to the patient concerning likely prognosis of treatment. If things go wrong with treatments, and occasionally they will, tell the patient and make a note in the records that they have been informed.

The most important advice when considering cutting corners is to ask yourself if you are changing your practice for the benefit of the patient or for your own financial or other benefit. And you know what my next piece of advice will be... if it's not for the benefit of the patient then it's not the right thing to do. So don't rush to forget everything they taught you in dental school and perhaps consider enrolling on a rubber dam course instead!

Claire Renton is a dental adviser at MDDUS

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

ANY of the commonest dental conditions, such as pulpitis or an apical infection, are usually accompanied by pain and/or swelling. Sufferers will therefore tend to arrive at your practice knowing that something in the tooth department is very wrong. As a result, the need for treatment is often anticipated and easily accepted. Once symptoms have been relieved, these patients are often grateful and amenable to having other diseased teeth restored or extracted. They may even pay their bill!

Periodontitis, however, tends to be more insidious. Often the only obvious marker is bleeding gingivae, about which many patients seem to be remarkably relaxed. Since it rarely causes the overt symptoms which are usually associated with dental disease, convincing patients that treatment is required can be difficult. Initial scepticism may be heightened by the fact that patients rarely perceive tangible post-treatment benefit. On the contrary, newly scaled teeth can feel 'rough' and sensitive.

Once these concerns have been addressed, the beleaguered practitioner often has to remind the patient that the periodontal treatment must be repeated (and paid for) periodically. Thus, persuading patients to undergo appropriate hygiene and maintenance phase treatment can be difficult even for experienced dentists who have been able to develop a trusting relationship with their patients. For the more recent graduate, faced with an overbearing and cynical patient, it can be a particularly daunting prospect.

The temptation in such situations can be to avoid confrontation by 'deferring' discussion of prevention and treatment of periodontal disease, secure in the knowledge that it may take many years for the resulting problems to manifest themselves.

Informing patients

Regardless of circumstances, failure to inform patients of clinical findings is unethical and may lead to serious censure. However, the ramifications for the patient's dentition of supervised neglect

can vary. For example, if caries are left untreated then the patient may return with both pain and awkward questions. Yet the resulting symptoms and loss of coronal tissue can often be remedied by a variety of restorative techniques, perhaps preceded by endodontics. Even where this is not feasible or unwanted, the resulting loss tends to be limited to the involved tooth.

Untreated periodontal disease, on the other hand, is often very difficult to stabilise and impossible to reverse. Furthermore, it is liable to affect a number of teeth, if not entire arches. Explaining this to a disgruntled patient who has "never heard of gum disease" can be very challenging. However, keeping schtum until these patients eventually return with irreparably mobile (and perhaps expensively restored) teeth is a recipe for complete disaster. As always, honesty and patience are the best tactics.

Build from the ground up

Maintenance of the supporting tissues must underpin the care of all dentulous patients. This philosophy starts with a comprehensive history which includes questions regarding home care regimens, previous periodontal treatment need and smoking. The subsequent examination will include visualisation of the soft tissues accompanied, at appropriate intervals, by pocket chartings.

All findings must be recorded in the clinical notes – this will assist treatment and help defend any future allegation of negligence. It is also essential when certain items of service in the Scottish Statement of Dental Remuneration are being claimed. This said, the inclusion of a basic periodontal examination (BPE) or six-point charting must not become a defensive or 'tick-box' exercise. These chartings must be carried out methodically to reflect the clinical picture and provide an accurate and credible basis for treatment.

Once the soft tissue examination is complete, radiographs may be required to assess the extent of periodontal bone loss. These films can be an exceptionally useful diagnostic tool. Furthermore, although X-rays should not be taken for purely dento-legal reasons, they also provide a definitive record of the patient's presenting condition which can be another extremely useful



BUT THE GUMS WILL NEED TO COME OUT.

means by which to defend an allegation of periodontal neglect. Remember that any decision to take X-rays, the technique used and the accompanying quality assurance should be informed by the relevant statutes and best practice guidelines.

If history and examination show the patient is periodontally fit and exercises good home care, then little more is required. Where disease is observed or where the patient's habits predispose to its onset, appropriate management should be discussed.

Informed consent

No intervention can begin without valid consent. However, since patients are often relatively unconcerned by a disease whose progress is generally slow and which causes relatively little discomfort, securing their agreement to recommended treatment can be problematic. Therefore, the consenting process must involve not only a description of procedures, potential complications, alternative approaches and costs, but also clear advice as to the risks of non-compliance.

Patients must understand that, while the rate at which supporting tissues deteriorate can be unpredictable, in most instances loss of dentition will be the ultimate end-point. Hopefully the fully informed patient will be keen to cooperate but, if having understood this advice, the competent patient withholds consent then treatment cannot proceed.

Sound advice

Active treatment must be complemented by home care advice. Flossing, brushing and smoking cessation instruction are essential components of achieving periodontal health and must be tailored to the patient's individual needs. Getting patients to floss or interdental brush in all quadrants daily is a particularly hard sell. I've heard all the excuses ("flossing pulls my fillings out" is a favourite), so it is important to be gently persistent.

Finally, treatment...

The next stage is to treat the patient's periodontal disease. This involves skills which are beyond the scope of this article and which

will be refined through experience and further education but it is important to bear in mind the chronic nature of periodontitis when treatment is being planned. Unless the management of a cooperative, conscientious patient has resolved and stabilised the periodontal condition, then periodontal therapy tends to be a continuous and repetitive process.

If it's not recorded, it didn't happen

It is my experience that the onset of advanced periodontitis is often accompanied by selective amnesia. Non-compliant patients who finally realise that their dentition is irreparably compromised rarely recall their own failings, focusing instead on any lack of care and attention on the part of their dentist. In such circumstances, a complaint or claim of negligence is likely.

The pathogenesis of periodontal disease tends to dictate that these allegations will emerge many years down the line so defence relies heavily on what is contained in clinical notes. These should always record the vital facets of each appointment, such as examination findings, consent and treatment outcomes. When dealing with periodontal problems, details of preventive advice and the patient acceptance and implementation of that advice should also be included. If it is evident from the records that the patient failed to cooperate with sound clinical advice then a lengthy dispute (and many months of stress) can be more easily avoided.

Perhaps due to the relatively subtle nature of periodontal disease, this aspect of clinical practice presents particular challenges. Motivating patients to attend for treatment and to maintain the subsequent improvements through scrupulous home care can be an uphill task. Where patients cannot be persuaded, it may take many years for the presence of periodontal disease to become apparent. By this time, the situation can be dire. Therefore, the implementation of appropriate and well-documented preventive education and periodontal treatment must form an integral part of every patient's care.

Doug Hamilton is a dental adviser at MDDUS

DIAGNOSIS

BLEEDING GUMS...

Day 1

Mrs M – a 48-year-old woman – calls her dental surgery to organise a routine check-up and clean and is given an appointment with a newly qualified associate dentist, Mr A. The patient attends the appointment and complains of swollen gums. She is a smoker and has a history of periodontal disease. Mr A explains how smoking can exacerbate the problem with her gums and Mrs M says she has booked a session with a cessation councillor.

AGAIN

Day 30

Mrs M attends the surgery as an emergency having lost a large filling in UL6. Mr A places a temporary filling and the patient returns two days later for the placement of a crown.

Day 37

Mrs M returns to the surgery complaining of swollen gums, pain and bleeding localised around UL6. On examination Mr A finds that some excess cement was left in place when the crown was fitted and admits that this might be exacerbating her pre-existing gum condition. He removes the cement and cleans the area and prescribes a chlorhexidine (CHX) mouthwash.



WEEK later the practice receives a letter of complaint from Mrs M regarding the dental treatment provided by Mr A.

She states that the dentist failed to diagnose and treat her periodontal disease despite seeing her on numerous occasions over a three-month period. Her gums are now in a "deplorable state with irremediable bone loss". She alleges that had she not attended the dental hospital her condition would have been allowed to deteriorate even more.

The practice manager investigates the complaint and asks Mr A for his written comments in response. The dentist states that on first seeing Mrs M he was aware of her history of periodontal disease and that she had undergone treatment for the condition at the practice over the last three years. In his initial examination the dentist recorded "no gingival swelling" and the treatment plan remained focused on monitoring the patient's oral condition.

He states that the problem with the crown at UL6 was identified and remedied and that he also provided advice on smoking cessation – both the benefits and temporary side-effects on the gums. Mrs M's decision to self-refer to the dental hospital and her refusal to see Mr A again meant the he was unable to provide any further advice and treatment.

Mrs M is not satisfied with the practice response and refers the case to the health ombudsman. An investigation is undertaken and the ombudsman upholds certain aspects of her case in regard to dental charges for the treatment but not in regard to the failure to diagnose and treat her periodontal disease.

In examining Mrs M's dental records an independent clinical adviser finds that the patient was informed of the poor state of her gums on numerous occasions in previous years and that she had undergone treatment with the practice hygienist. Indeed in the period after her initial diagnosis the patient had failed to attend numerous appointments with the hygienist in regard to her condition.

In regard to the treatment to UL6 provided by Mr A, the adviser states that it is possible the fitting of the crown and excess cement may have exacerbated the pre-existing gum disease. However, the dentist could not be said to have caused the condition or contributed to any significant decline in the state of her gums over the period.

The adviser can only fault the practice in perhaps not communicating effectively with Mrs M on the significance and importance of gum disease and the necessary routine care to prevent the condition getting worse.

Key point

- Ensure that patients understand clearly the significance of periodontal disease and the likely outcomes should treatment advice be ignored.
- Avoid the charge of "supervised neglect" by using every appointment as an opportunity to remind patients with gum disease of the need to maintain good oral hygiene.
- Keep adequate notes of home care advice given to patients and the importance of flossing, brushing and smoking cessation.

Day 65

7

The patient attends the practice again complaining of bleeding gums. Mr A finds bleeding on probing and gingival inflammation throughout the mouth. Mrs M states she has recently quit smoking and the dentist explains that bleeding is a sign of improved blood flow to the gums and this is normal. He reassures her that the bleeding should soon settle if good oral hygiene is maintained and cigarettes are avoided. He prescribes CHX mouthwash again for five days.



Day 81

The practice is phoned by Mrs M to complain that she is very unhappy with the treatment provided by Mr A. Earlier that day she had referred herself to the dental hospital because of the persistent swelling and bleeding in her gums. She said the attending dentist diagnosed periodontal disease as well as an abscess and evidence of cement and pus in her gums where the crown had been fitted at UL6. He prescribed an antibiotic and also informed her that her gum disease had not happened overnight and that she must get immediate treatment. Mrs M is offered another appointment with Mr A but she insists on seeing a different dentist.

OUT THERE

WAX WORK An ancient cracked canine tooth repaired with a filling of beeswax may be the earliest known example of therapeutic dentistry. Analysis on a 6,500-year-old human lower jaw discovered in an Italian cave found wear and tear from eating and using teeth for tasks such as softening leather. Source: Dentistry

WEIRD WISHES A survey by the Chicago Dental Society unearthed a list of odd patient requests. One wanted to save their extracted teeth to make a necklace, another asked their dentist to identify dentures found in a pub toilet and another wanted their dog fitted with braces.

DRILL ME A TUNE A dentist in Indonesia has modified his drill to play music via an MP3 player in a bid to soothe scared patients. Dhanni Gustiana blocks out the distinctive buzzing sound with patients' favourite tunes and also attaches a toy to help nervous children. Source: Metro

SHARK TALE Shark teeth are so sharp and effective because their surface contains 100 per cent fluoride, German researchers have discovered. They also never get caries and replace their teeth several times throughout their lives. Source: Daily Mail



CROSSWORD

ACROSS

- L Closed sac (4)
- Classitistic (albert (1)
- Clean teeth (abbi.) (1,5,1)
- 9 Local anaestnesia (abbr.) (1,1,5)
- 10 Root canal paste (brand name) (6
- 12 Group of seven (6)
- 14 Relating to the cheek (6)
- 19 Relating to the lips (6)
- 20 Relating to the tongue (7
- 21 Temporary filling material (brand name) (5)
- 22 Movement of tooth (8)
- 23 Post and _____, restoration (4)

DOWN

- 1 Miming game (8)
- 2 Most morose (8)
- 3 Fingers (6)
- 4 Law-breaker (5
- 6 Japanese car maker (6
- 7 Questions (4)
- 11 Manicure tool (8)
- 13 Yearly (6
- 15 The Windy City (7)
- 16 Distributes (6)
- 17 Large mollusc (4
- 18 Door handles (5)

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





MDDUS are offering a £1,000 grant to a successful applicant from a dental training practice where both the trainee (commencing training in August 2012) 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 February 28, 2013 will be considered.