



EMPOWERING

TIMES

THE RISE OF WOMEN IN DENTISTRY

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AN MDDUS
PUBLICATION





Welcome to your SoundBite

NOT so long ago dentistry was a profession reserved predominantly for men. Fortunately times have changed, so much so that the majority of those entering dentistry are now female. This gender shift has met with both support and criticism and it also raises a number of important questions for dental training and workforce planning. As a young female dentist myself, I take a look at this issue in my article on [page 4](#).

One young dentist who is making waves in the profession is entrepreneur David Stone. On [page 6](#) he talks about the sudden flash of inspiration that led him to set up a business selling loupes while he was still at dental school, and the impact it has had on his career.

Last year the GDC published an updated set of professional standards that all dentists should be familiar with. MDDUS

dental adviser Claire Renton looks at what's new on [page 10](#). There are so many elements of risk management to consider in the practice of dentistry that it's easy to forget about the potential pitfalls of day-to-day work. On [page 12](#), MDDUS dental adviser Doug Hamilton takes a journey through a typical routine dental visit and highlights some key issues to consider along the way.

If you've ever thought about a career in endodontics then our career feature on [page 8](#) discusses what it's like to work in this challenging specialist field that focuses on the treatment of the dental pulp and surrounding tissues. And our case study on [page 14](#) highlights poor record keeping and a fractured instrument.

• Sameera Teli
Editor

CAMPAIGN AGAINST DFT PAY CUT

THOUSANDS of people have signed a petition protesting against proposals to cut the salary paid to dental foundation trainees in England by more than £2,000.

The petition, organised by the British Dental Association, calls for the plans to be abandoned. Posted on the government's e-petitions website, it had attracted almost 6,700 signatures by the beginning of June. The campaign has also spread to Twitter and Facebook.

It came in response to government plans to reduce newly qualified dentists' pay by almost eight per cent as part of a raft of efficiency savings. The move would mean those starting DFT in September 2014 would receive more than £2,000 less than those currently completing their DFT year.

The BDA fears the cut will increase the debt burden on dental graduates and damage morale.

Despite criticism from within the profession, the Department of Health remains committed to implementing the cut, which would reduce trainees' salary to £28,076. They say this is being done to bring DFT pay in line with the pay given to foundation year one doctors, "to regain a level playing field in this area".



EXTRA DENTAL LEARNING RESOURCES

NHS Education for Scotland (NES) is to fund additional educational resources to dental training practices aimed at further supporting the learning needs of the entire dental team.

The range of new materials will be free to access and includes an interactive programme on oral cancer and a suite of modules on communications skills.

NES Postgraduate Dental Dean David Felix said: "These additional learning resources will allow all members of the practice - dentists, dental care professionals, practice managers, receptionists as well as the new graduates - to undertake verifiable continuing professional development (CPD) at a time and location of their choosing."

It's estimated those working in the training practices could undertake 15 to 20 hours of CPD over a 15 month period. The practices appointed for the August 2014 to July 2015 training year will have priority access to the resources.

CONSULTATION OF SPECIALTY STANDARDS

DENTISTS are being asked for their views on the GDC's draft *Standards for Specialty Education* guidance.

The regulator wants to know if the guidance is clear, if there is anything missing or if anything should be removed. They also want to understand the impact of the standards on stakeholders.

Find out more on the GDC website: <http://tinyurl.com/noulylq>



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OPTIMISM OVER FUTURE OF DENTISTRY

MORE than a third of dentists are optimistic about the future of the profession over the next two years, according to a GDC survey.

The 2013 *Annual Survey of Registrants* found 37 per cent were optimistic, a two per cent increase on last year. Of the 3,600 people questioned in late 2013, 31 per cent said they were pessimistic, down two per cent on last year.

The survey also found confidence in the GDC is high with 67 per cent of respondents agreeing that the regulator is working effectively (26 per cent disagreed). Confidence with the GDC grew the longer an individual had been on the register.

Nearly half of those surveyed (46 per cent) said they had come across an issue they felt should have been raised as a concern. Dental professionals were more likely to have raised a concern to someone in their workplace (39 per cent) than to the GDC (five per cent).

BRITISH SWEET TOOTH CHALLENGE

MORE than a quarter (27 per cent) of the UK population eats snacks high in sugar at least twice a day according to a survey published by the British Dental Health Foundation.

The BDHF reports that London is the UK's biggest snacking region, with one in five Londoners (20 per cent) eating snacks high in sugar three times a day or more, followed by the North East (17 per cent) and one in 10 in Scotland and Wales (11 per cent and 10 per cent respectively). In contrast, 33 per cent of the population in the South West claim to never eat snacks high in sugar.

Only two per cent said they were influenced by the effect that food and drink could have on the appearance of their teeth while 29 per cent said that body weight/shape may make them think twice about picking up a sugary snack.

The results have been published together with Listerine as part of National Smile Month, which ran from 19 May to 19 June. The UK's biggest oral health campaign is an annual reminder of how to improve oral health and why maintaining it is vital to overall wellbeing.



GDC CONSULTATION REVEALS HOW IT SPENDS ARF INCOME

THE General Dental Council spent £26.6 million on its fitness to practise function last year, new figures reveal.

The amount represents almost 80 per cent of the regulator's total spend of £33.9 million in 2013.

Other key expenditure on statutory functions included £3.7 million for maintaining the register, including processing applications, collecting the annual retention fee (ARF) and checking registrants have met CPD requirements.

A further £1.1 million was spent quality assuring 17 providers of dental education and training. A total of £800,000 was spent on the Dental Complaints Service which last year dealt with 1,876 private dentistry complaints.

Overall, the GDC said it raised £31 million from ARF in 2013 but spent £33.9 million. The shortfall was made up by fees received from dentists sitting the overseas registration exam, income from investments and financial reserves.

The spending breakdown was revealed in a consultation document asking dental care professionals for their views on the approach the GDC intends to take when setting the ARF, compulsory for all practising dental care professionals. The consultation closed on June 4, 2014.

It follows a 2013 review of the fee that revealed a lack of clarity in five areas: why the GDC charges fees; the language they use about charging fees; how they spend the money; why they charge different registrant groups different amounts; and the reasons why fees would be increased.

As well as asking for opinions, the consultation document tried to address these five areas. It revealed that the average cost of investigating a complaint last year was £1,100 while the average cost of a case heard was £78,000.

CONCERNS OVER DENTAL JOBS

MORE than one in 10 new dentists hadn't found a job before their training ended last summer, research has revealed.

Around 12 per cent of trainees had finished training in 2013 without a post to go to, according to the British Dental Association's *Survey of Foundation Dentists and Vocational Dental Practitioners*.

For the second year in a row, a growing proportion of trainees in England and Wales who took part in the survey reported they were taking up posts in primary salaried or hospital dentistry. It remains to be seen whether this is indicative of a wider trend.

The BDA says the research adds to concerns over job availability for new dentists. Their 2013 *Dental Business Trends Survey* found that

more than 10 per cent of current associate dentists could be officially classed as under-employed, meaning that they wanted to work more hours and were available to do so within two weeks.

It also follows warnings from Health Education England and the Centre for Workforce Intelligence at the end of 2013 of a potential over-supply of between 1,000 and 4,000 dentists in England by 2040 if the current number of places for dental students is not reduced.

Judith Husband, chair of the BDA's Education, Ethics and the Dental Team Committee, said: "This research suggests that employment opportunities in general dental practice are not as readily available as they once were for newly-qualified practitioners. In doing so, it adds to the evidence base that must be considered as recommendations to reduce the number of places to study dentistry are contemplated.

"These are difficult decisions that must be made, implemented and monitored with great care, and in dialogue with the profession and the academic institutions they will affect."

GENDER SHIFT

THE CHANGING FACE OF DENTISTRY

The number of women entering the profession has grown steadily in recent years. *SoundBite* editor **Sameera Teli** investigates

// MUST say it is a nice change to have a young lady as my dentist.”
These were the words of a recent elderly patient of mine. He had been attending the practice, which I had just joined, since he was a young man.

As I mused over his comment, I thought back to the changes the practice had undergone over the years and discovered that there had indeed only ever been male dentists here. Yet within the last two years, the practice now has a female dentist majority.

This gender shift is reflected more widely across the profession and is changing the face of the dental workforce, raising many questions along the way.

Men only

Things have come a long way since the late 19th century when only men were allowed to qualify as dentists. The 1897 census in England counted 116 women dentists, but none held a Licence in Dental Surgery (LDS). Just two years previous in 1895 Lilian Murray (later Lindsay) attained her LDS in Edinburgh, becoming Britain's first qualified female dentist.

But her career path was not easy. She had first applied to the National Dental Hospital in London but was refused entry to the building to attend her interview for fear of distracting the male students. Needless to say her admission to study there was also declined.

Fortunately Lilian was welcomed north of the border and she went on to graduate with honours from the Royal College of Surgeons of Edinburgh. It wasn't until 17 years later that women were finally allowed to sit dental examinations in England.

Even though women dentists gradually became a more accepted presence, research shows that as late as the 1960s they were still being encouraged to enter certain branches of dentistry. Fields such as maternity, child welfare and school health services were considered more suited to women.

Women on the rise

Since then, things have changed significantly. A study of the career development of male and female dentists published in the *British Dental Journal* in 2000 showed that in 1975 up to a quarter of new dentists were

female. Today more than half of UK dental students are female and by 2020 it is estimated that over half the dental workforce will be female. This is also true outside the UK, with an upward trend in female dentists worldwide.

As a young female dentist, I wonder how this gradual feminisation of dentistry will impact our futures, and the significant consequences it will have for the wider workforce.

The *NHS Dental Statistics for England 2012/13* report revealed significant gender differences in relation to the age of dental professionals, hinting at how the profession is likely to change in the years ahead. The under-35 age group is largely female (56.1 per cent) while the majority (76.4 per cent) of dentists aged over 55 are male.

In the past, dentistry's big decision-makers have overwhelmingly been older men but it is notable that the General Dental Council has appointed its first female chief executive, Evlynne Gilvarry. Of all the 128 British Dental Association presidents since 1880, only five have been women, the first being Lilian Lindsay in 1946.

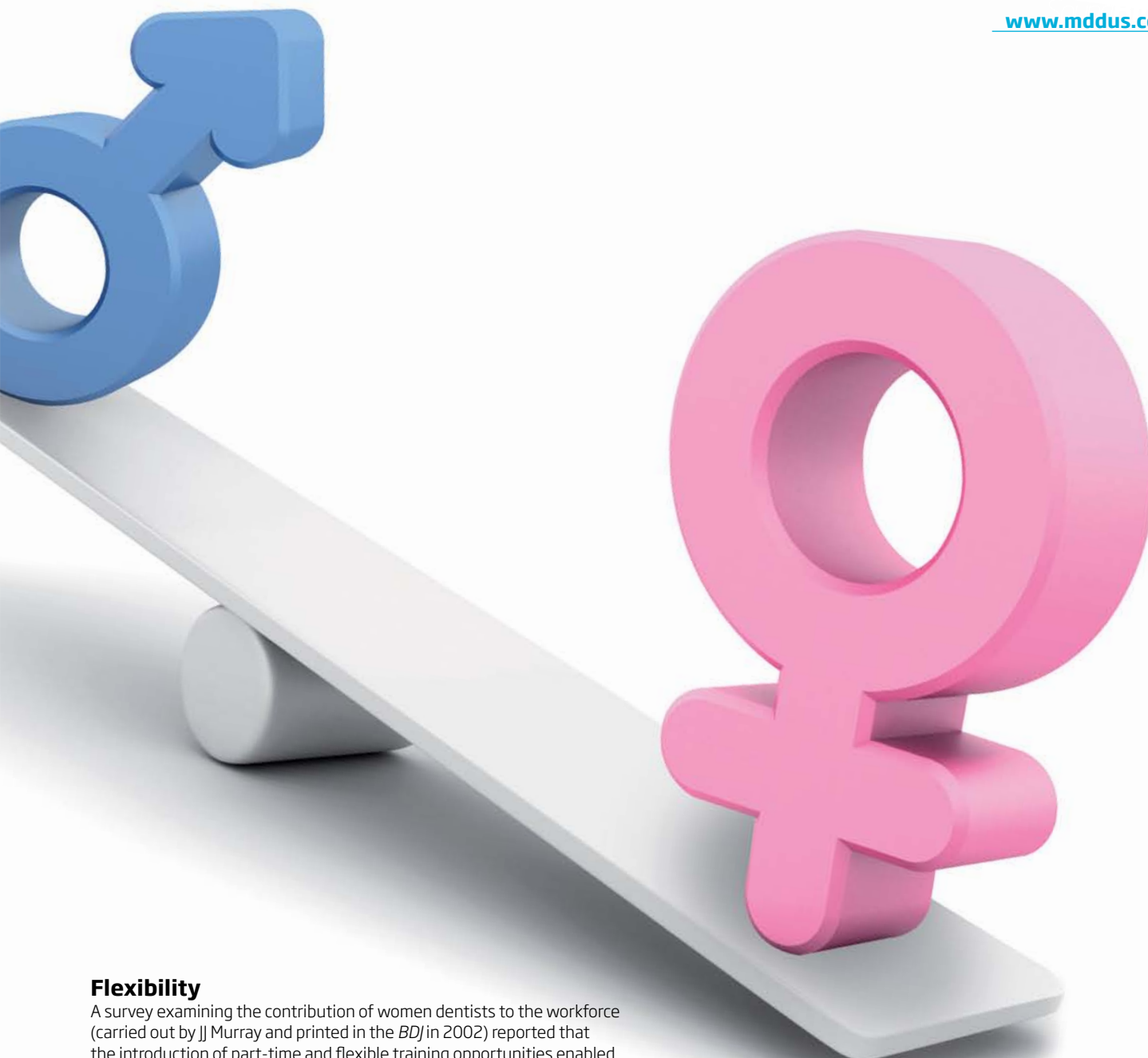
Planning for change

GDC figures of the current specialist lists show that although female dentists represent the majority in dental public health, paediatric dentistry and special care dentistry, men continue to dominate all other specialist fields. What will happen once this predominantly older male cohort of dentists retires?

The increasing number of female dentists makes it imperative that women be recognised as vital for the future workforce. But will training pathways need to be restructured to accommodate the different needs of female dentists? Should they be?

In a recent Q&A with *MDDUS Summons* magazine, the BDA's Judith Husband said: "Research has consistently demonstrated women dentists tend to see fewer patients, spend more time with patients, are less likely to own practices and will take career breaks. Society and legislation have moved to support both partners in relationships with caring responsibilities with paternity leave."

"The generally accepted trend is that the profession will be less productive in terms of volume of clinical work and this has a significant impact for workforce planning."



Flexibility

A survey examining the contribution of women dentists to the workforce (carried out by JJ Murray and printed in the *BDJ* in 2002) reported that the introduction of part-time and flexible training opportunities enabled women to pursue the same goals as male colleagues, but the research confirmed that there were still few women reaching senior positions.

Some of the survey's respondents remarked that for women dentists there was little flexibility in university clinical posts and career pathways, which remain based on traditional male working patterns.

The survey noted: "The training pathways and the necessity for substantial research and postgraduate qualifications to reach the highest posts were considered obstacles when combined with raising a family." Perhaps some of the prejudices we have seen historically from Lillian Lindsay's days continue to persist?

JJ Murray's survey of 4,500 women dentists also revealed almost half of them work full-time and half part-time, with the main reason for part-time work being caring for children. A 2006 study in the *BDJ* called *The feminisation of the orthodontic workforce* found female dentists took more career breaks than men with breaks lasting an average of nine months compared to men's four month breaks. As a result, women dentists who take a career break can be expected to have a working life 25 per cent shorter than a dental practitioner who does not take a career break.

There have been many high profile comments on the "feminisation" issue in medicine. Critics have raised concerns over the impact of large-scale part-time working which they say will require greater investment in training. Other more positive comments have come from the likes of the Academy of Medical Royal Colleges who believe the NHS should view the changing nature of the medical workforce as an opportunity rather than a threat, adding that "opportunities for flexible working are increasingly sought by and benefit both male and female doctors."

At some point, I will likely consider taking time out of my career to

have children, and thus be a part of these statistics. Changes including the planned new UK laws for shared parental leave and pay may level out some of the potential imbalance but more will no doubt have to be done.

There are also knock-on effects in financial terms for future dentists. The BDA estimates that dental students who have begun their courses in 2013/14 can expect to face debts as high as £60,000 at the end of their studies. How will this affect these future graduates, considering half of them are likely to be working part time? Will women struggle to re-coup the financial investment they have made in building up their skills?

The reasons why more women are entering dentistry aren't clear but the so-called feminisation of the workforce shows no signs of slowing down. It seems the profession will have to get used to seeing a greater number of "young lady" dentists in future.

Sources:

- *BDJ*, Women and the world of dentistry: tinyurl.com/nlqbjug
- *BDJ*, A study of the career development of male and female dental practitioners: tinyurl.com/oqzk7sn
- *BDJ*, A review of the contribution of women dentists to the workforce, JJ Murray: tinyurl.com/o3jaa5b

Sameera Teli is a dentist and editor of SoundBite

A CLEAR VISION

Entrepreneur David Stone was still a dental student when he spotted an opportunity to launch his own business. He tells *SoundBite* about his success

If you're going to have a 'eureka moment' that leads to a successful business idea or invention, then it would probably be best not to have it while you're studying to be a dentist. After all, this is not one of those courses where students don't have to show up until there's an exam to sit. But then the thing about sudden flashes of inspiration is just that – they're sudden and unexpected.

So when David Stone, while in his third year of dentistry at Cardiff University, realised there was a gaping hole in the student market for loupes – magnifying lenses to help see into a patient's mouth more clearly – the timing of his discovery was perhaps not ideal.

He had been suffering from a bad back – one of the banes of a dental career, with musculoskeletal problems a major cause of early retirement – and was looking for a way to ease the situation. "It was in my third year of this five-year course," he says, "and I thought to myself loupes seemed like a good idea. They're magnified so you don't have to lean in quite as far to see in great detail what you're doing."

Coupled with this, he had also noticed that whenever his dental restoration work on one of the dental school's phantom heads was checked by one of two supervisors, it was the person wearing the loupes who picked up his mistakes more clearly. So here was a chance to kill two birds with one stone, he thought.

But when he started investigating the possibility with a loupes sales representative who was visiting the university, he was struck by the price. The loupes themselves were around £800 but, more importantly, it was the cost of the parts that grabbed his attention. He explains: "Whenever I go to buy anything, I try and work out what's going to break and how much it's going to cost to fix. So I asked how much it would cost to replace the arm of the frames. When she said £250, I thought, that seems like a hell of a lot of money for a bracket with a hinge."

Affordable solution

David loved to haggle and had taken on street sellers from India to Morocco, and now the barterer within took over. But instead of trying to drive down the selling price in this instance, he went on the hunt for affordable loupes. Through the internet, he found a manufacturer that made loupes that were fit for purpose – and at a fraction of the price. Then

some of his friends tried them out and decided that they would like a pair too, so he bought five more and passed them on at cost price.

Loupes take some getting used to and they do make you look "a little geeky", says David, but nevertheless he noticed that the arrival of several pairs in the phantom head room sparked considerable interest, far beyond what he was used to seeing on the once-a-year visit from the loupes salesperson. He identified two reasons for this: the much lower price and also the fact that fellow students could try them out for more than just a few minutes, with no urgency to buy there and then.

That's when he had his eureka moment. "It was at that point that I thought, hang on, there's no end of dental students in Cardiff!" And so, in 2009, his firm UKLoupes was born.

He bought some more pairs – "They got snapped up" – and then a few more, and fairly soon, with a handful of loupes at the ready in his hospital locker for potential buyers to try out a week at a time, he noticed that something of a trend had

begun. "The more the dental students wore them around the hospital, the more other people were looking at them and saying, 'Oh, I wouldn't mind having a go', without even coming to see me first. They would then say to me, 'I tried John's pair – can I just have some exactly like his?'"

Growing success

He knew he was onto something when even

some of the lecturers and visiting dentists, intrigued by the sudden popularity of loupes, bought from him.

At this point, David was only selling his loupes locally and found that with some judicious time management he was easily able to keep up with his studies. "I didn't struggle too much. I was a mature student, as I'd done a degree in biology before, and I was a little bit better at managing my time than other students. And yes," he says, "I was still out there doing normal student things and having fun!"

But when he started getting enquiries from further afield, he knew he was going to need help. One of David's gripes about the dental course was the lack of business training, particularly as so many dentists go on to run their own practices, essentially setting up in business. Some of his lecturers sympathised with him but said there were ethical implications. "The course had to teach us how to fix teeth and not how to fix teeth with a view

"David hit upon the idea of supplying his own loupes to fellow students while seeking an affordable solution to his back pain."



Main image: Dentist and UKLoupes founder David Stone models a pair of loupes.
Below, from left: UK sales manager Dan Kiel, David Stone and Barts sales agent for UKLoupes, Michael Myint.



to making money, because it is NHS-based."

As a result, feeling he could easily get out of his depth, he sent an email to the university's business school looking for a suitable candidate. One of those who responded was Dan Keil, now a fellow director of UKLoupes. "I interviewed them in the university café and Dan was head and shoulders above everybody else," says David.

With Dan's help the business started to expand. Their first stop was Bristol University, just up the road, where he admits to bringing in pizzas to tempt the students to attend the presentation. He laughs at the memory: "They'd come along, eat the pizzas, get their greasy hands all over the loupes and then leave." They also entered and won a number of business start-up competitions, providing small amounts of investment cash, and got funding for a business mentor through the Wales Innovators Network.

Expansion has taken them into dental schools across the UK, where they have a number of sales agents helping to market their loupes. They also now sell internationally, with enquiries from the USA, India, Australia and all over Europe.

One early and extremely beneficial piece of advice, says David, was that they should put their prices up. The mentor felt

the low price was sending the wrong message about the quality of their loupes. "So, even though we were only putting our prices up to about half that of our competitors, we probably doubled our profit margin!"

All the while they were expanding, both David and Dan continued with their studies. Then, after qualifying, David started his vocational training year in Cardiff. Once he'd completed that, he decided that not even his time management skills could cope with the extra workload. "I thought, this is getting a bit too much for me, what with answering emails and boxing up loupes at 11 o'clock at night."

So while he remains a partner/director of UKLoupes, Dan now runs the company on a day-to-day basis, leaving David free to work full-time as a dentist in Keynsham, while also taking a masters degree in implants at Bristol University.

Looking to the future

Clearly not one to sit on his laurels, David is looking to open his own dental practice in the near future and is also keen to launch a dental entrepreneurial competition - which he plans to call "Dragon's Dental" - as one way of addressing the lack of business training in dentistry. "I'm also thinking of setting up a website with some dental business-related resources for young dentists, not just dental students. I'd like to give something back," he says.

The whole UKLoupes experience has been fantastic, says David, and even though he has broadened his interests, for now it remains the thing he's known for. "I'm recognised as that dental student who sells loupes, and I'm not even a student," he says, laughing. "I think that's going to follow me, probably throughout my career. But that's fine - you know. I'm proud of how UKLoupes has turned out."

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



THE ROOT OF THE PROBLEM

What are the opportunities for a career in endodontics?

An estimated 14 million root canal treatments are completed in the UK every year and, thanks to advances in new technologies and techniques, treatment success rates can be 85 to 90 per cent or better.

The branch of dentistry concerned with the biology and pathology of the dental pulp and periapical tissues is endodontics. It also involves the prevention, diagnosis, and treatment of diseases and injuries in these tissues.

In the broadest sense, all procedures that maintain the health and the vitality of pulpal tissues can be considered as relevant to endodontology. Once the pulp becomes diseased, practitioners in this field perform a variety of procedures, most commonly endodontic therapy or root canal treatment. They also provide endodontic retreatment, surgery, and treatment of cracked teeth or dental trauma. Patients often present as emergencies seeking relief from pain.

The General Dental Council maintains a specialist list for endodontics and only registered dentists accepted onto this list can use the title "specialist" endodontist.

Entry and training

For those intending to undertake endodontic training leading to specialist status, the GDC's minimum entry requirement is two years of postgraduate foundation training (or equivalent) which may include a period of vocational training (VT) and may also include

a period of training in secondary care in an appropriate specialist environment.

It is useful (but not essential) for budding specialty trainees to hold membership of one of the Royal Colleges including MJDF (Membership of Joint Dental Faculties RCS England), MFDS (Membership of the Faculty of Dental Surgery RCSEd and RCPS Glasg) or MFD (Membership of the faculty of Dentistry RCSI).

The usual training period for endodontics will be three years (4,500 hours) full time but part-time training is also possible. The programme content is flexible but tends to be roughly 60 per cent clinical, 25 per cent academic and 15 per cent research.

provided at each stage.

Specialist training will take place in programmes approved by the relevant postgraduate deanery and under the supervision of a designated lead trainer (educational supervisor). Appraisals will be held every six months, to include self-reflection on progress as well as trainer assessment leading to a personal development plan.

After successfully working through this programme, a certificate of completion of specialty training (CCST) is awarded by the GDC on the recommendation of the deanery in which the training took place.

More information on training pathways is

"Endodontics is a team effort with you, the patient and, crucially, a good assistant"

Training may be flexibly delivered through a variety of methods including a structured, taught masters/doctorate degree programme or through a work-place based programme (specialty practice or hospital based training). Whichever route is followed, trainees will have to demonstrate certain minimum outcomes in the range and competence in requisite skills. Development of competence will usually take a systematic path progressively building on core skills. This means the learning process has to be carefully tracked and effective guidance

available on the British Endodontic Society website.

The job

Endodontic specialists can choose to practise in a variety of settings, including private referral clinics, within general dental practices (offering NHS or private treatment), in a hospital setting or in an academic/research post.

Those looking to set up a practice offering endodontic treatment will require a referral base and the necessary training and will



Q&A

Mark J Hunter,
specialist endodontist,
teacher and secretary of the
British Endodontic Society

• What attracted you to a career in endodontics?

I was encouraged by a teacher who was aware that I had an aptitude for doing endo. I discovered an area of dentistry that was challenging, intriguing and captivating. To save teeth that would otherwise require extraction is matched only by the privilege we have as dentists to relieve a patient of one of the worst pains that can be suffered.

• What do you enjoy most about the specialty?

I enjoy treating the person who owns the tooth. It is not just about doing a challenging and intricate procedure, it is about taking an often frightened patient and delivering them through the process with a positive experience. Winning the trust of another is where the greatest return is to be had.

• What do you find most challenging?

Gaining sufficient experience to be confidently effective is one of the early challenges we all face. Once this has been achieved, the biggest continual challenge is to gain and maintain the patient's trust. If a patient is struggling to let you get on, it can prevent you from performing at your best. This is why endodontics is very much a team effort with you, the patient and your assistant. I can't over-emphasise the value of a good assistant. Sure, there are technical challenges such as sclerosed canals, 90 degree curvatures with a small arc of radius, previous misadventures, fractured instruments, ledges and blockages. These can be overcome, but not if the patient is unwilling to let you get on with it.

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

I have learned that complacency can teach one a harsh lesson. Positive outcomes cannot be assumed and you should always expect the unexpected. When you see a lateral canal filled very nicely, ask yourself how much skill really went into filling this and how much was down to good luck? Doing endo can be a humbling experience. When things don't go according to plan, don't try to cover up, always keep the patient informed, be open, honest and realistic.

• What personal attributes do you feel are important in endodontics?

The most important attribute for achieving good outcomes is patience, both with the patient and yourself. If you are performing urgently or under pressure, then this tends to give a poorer outcome. A better outcome can often be had by returning to a case at a later date rather than trying to complete it in a hurry. Missing or difficult to negotiate canals one day can seem much easier to manage when one is refreshed at a subsequent visit. The other great attribute for doing good endo is empathy. Letting patients know they can stop treatment if the need arises helps them to feel more relaxed and in control.

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

Total commitment is required for endo as it can be tough. Don't specialise too soon - I feel I'm a better endodontist because I have a facility and ability in other areas of dentistry. (It relates back to the idea that we treat the person who owns the tooth, not just the tooth.) A good endodontist will have a range of early dental experience such as extracting teeth, making dentures, recognising and treating soft tissue disorders as well as treating difficult uncooperative children to name but a few.

You also have to be good at giving local anaesthetic, as well as restoring the tooth for the referring practitioner with a core or perhaps a post-retained core foundation. It helps to be a good diagnostician which means being able to listen and, when things don't make sense, to stand back and admit that we don't quite know what is going on. Endo is a wonderful, challenging area of medical expertise and intrigue, with ongoing scientific advances on many fronts, and countless gadgets and gizmos to help you on your way.

benefit from much experience gained during postgraduate training. Referral endodontic practice works side-by-side within general dentistry, however it is often necessary when patients are being treated for complex restorative work.

The specialty relies on a number of key pieces of equipment including an endodontic microscope, a torque controlled motor for engine driven rotary nickel titanium instrumentation, digital X-ray equipment, an electronic apex locator and obturation devices and systems. These can involve a considerable financial outlay but are advantageous to ensure efficient endodontic treatment - it is well worth seeking advice before making any big decisions. It must be said that a good trustworthy assistant is perhaps the most valuable element of a successful practice, more so than any of these devices and pieces of equipment.

Membership of professional organisations such as the British Endodontic Society offer a chance to maintain your professional skills and keep up-to-date with the latest developments in the specialty, as well as to share ideas and expertise with fellow dentists and specialists.

Useful links:

- British Endodontic Society - www.britishendodonticsociety.org.uk
- GDC specialist lists and curricula - tinyurl.com/lp7s728

WHAT'S NEW WITH THE GDC?

Last year the GDC launched an updated set of standards for dental professionals. MDDUS dental adviser Claire Renton offers a quick low-down on what's now expected



S you know the GDC is the regulatory body for dental healthcare professionals, but what does that really mean for us as dentists? We pay an annual retention fee to be on the register but what do we get for our money?

To give you a hint, the not-so-catchy strapline for the GDC is: "We regulate dental professionals in the UK - We set and maintain standards for the benefit of patients".

What they have omitted to say is that they prosecute dentists if they think they might not be fit to practise. All well and good you might think; those whose treatment is so poor that they have harmed patients probably shouldn't be allowed to practise. But a quick look at the homepage of the GDC today headlined that on 21 May this year a dentist was "struck off for poor record keeping". Yes, that's right ...struck off for poor record keeping! I'm not familiar with that case and this was only a headline but the message here is that times are changing. The GDC is keen to prosecute and lots of good dentists are finding themselves in the glare of the regulator's headlights.

New rules

In the first quarter of 2014, MDDUS had nearly four times more members referred for a GDC investigation as in the same period in the preceding year. Why? Well it's difficult to be certain but I don't think dentists have got worse

in the last 12 months! What did change was that at the end of September 2013 the new guidance *Standards for the Dental Team* came into force. This document produced by the GDC is essentially the rule book. If you've not read it yet, might I suggest you go on the GDC website and download a copy.

Be warned, it's not a great read. There are no interesting characters and the ending is as dull as the beginning. However, it is

"The advice is simple: know what the rules are, keep up-to-date with changes and ensure that you treat patients the way you would treat someone you are fond of"

essential reading for practising dentists; it tells us what we must do for all our patients. Interestingly, it divides the rules into those that "must" be obeyed and those that "should" be obeyed, then goes on to define that "should" is essentially "must" except in exceptional circumstances!

In truth, it's a fairly sensible set of rules for professional people to be abiding by. The document is laid out according to nine basic principles:

1. Put patients' interests first
2. Communicate effectively with patients
3. Obtain valid consent

4. Maintain and protect patients' information
5. Have a clear and effective complaints procedure
6. Work with colleagues in a way that is in patients' best interests
7. Maintain, develop and work within your professional knowledge and skills
8. Raise concerns if patients are at risk
9. Make sure your personal behaviour maintains patients' confidence in you and the dental profession.

Consenting adults and others

So what's new? Well there's a whole set of rules concerning consent, so it follows that it's important to ensure patients are fully informed of treatment proposals, are given written estimates for their treatment and that there is a note in the records detailing the options discussed and something to say that they have consented or agreed to a particular treatment. It's not necessary to have a specific consent form for dentistry carried out on conscious patients but it is essential to make a note that consent has been obtained verbally.

You must, however, have a signed written consent form for patients being treated under sedation or general anaesthetic. I think it's also a good idea to have a signed form when the treatment is going to take a long time, is complex or expensive. Why? Well, it's common for patients to claim that they did not consent to treatment when it has gone wrong and it's much more difficult to defend if there is nothing in the notes to support the dentist's position.

Banging on about records

Other aspects of record keeping are also prominent issues within the guidance. I can't think of a single clinical GDC case that hasn't also had charges relating to some aspect of record keeping. I know defence organisations always bang on about record keeping but while good records helped in defending a claim in the past, nowadays they might just keep you in a job. The standard

expected of our record keeping is that contained in the pithily titled *Clinical Examination and Record-Keeping: Good Practice Guidelines of the Faculty of General Dental Practice*. It's an essential read and as most of our dental records are on computer it's possible to make up templates to fill in to ensure the essential information is present.

As an aside, in Scotland records are increasingly being requested from Practitioner Services to check that the claim made for payment is justified, so for example if you are claiming a 1a examination the claim might be considered unjustified if you haven't assessed and recorded any malocclusion. So that's another document to read - the *Statement of Dental Remuneration*. In England and Wales, the situation is similar. It's important to ensure that your records show you have completed all necessary assessments and proper recordings before making any claim for payment.

Take care out there

The new GDC standards also include some subtle but important changes regarding when dentists are required to notify the regulator of any criminal charges. Before September 2013 the GDC only required notification by a dentist once they had been convicted of a crime but now dentists have to notify the GDC if they have been arrested, charged or even accepted a formal Adult Warning (Police Caution in England). So beware! No ridiculous speeding, being drunk and disorderly or getting caught short on the way home from a night out. Not that you would!

I am sorry if all of this scares you. It shouldn't. The advice is simple: know what the rules are, keep up-to-date with changes and ensure that you treat patients the way you would treat someone you are fond of. If you are in any doubt, give us a ring on the advice line. We are always happy to chat things through.

GDC standards on the go

THE GDC has developed a new mobile website dedicated to its *Standards for the Dental Team*.

Dentist can access the new site via mobile phone or tablet and it includes not only the *Standards* but also the interactive *Focus on Standards* content which is currently available on the main GDC site. The mobile site includes case studies, FAQs and guidance to help registrants apply the *Standards* in practice.

To access the mobile site go to standards.gdc-uk.org

Claire Renton is a dento-legal adviser at MDDUS

RISKS IN THE

MDDUS dental adviser **Doug Hamilton** takes a journey through a routine dental visit to highlight some of the risks dentists face along the way

IN A number of previous *Soundbite* issues we have looked at the potential dento-legal pitfalls which are inherent in many aspects of clinical practice. The areas considered have ranged from complete prosthodontics for the edentulous patient to elective cosmetic interventions for those who are fundamentally dentally fit.

The underlying message which I hope has emerged is that dentistry, while extremely important and rewarding, also requires the practitioner to assess and manage a seemingly never-ending series of risks on a daily basis.

Much of this process is mandatory. Ever wondered why rainforests are disappearing? Wait until you are presented with your first practice inspection checklist. Everything from the immunisation of staff to participation in basic life support training must be verified.

Yet, these practical safety requirements, while very important, do not offer a comprehensive mechanism for minimising the possibility of adverse outcomes. Risk management is also applied at a less formal, even intuitive, level and is often a product of application and experience. In fact, many seasoned practitioners will instinctively implement and refine their systems of work as a result of previous incidents and near misses.

To illustrate this point, let's follow a patient on an imaginary 'journey' through a routine dental visit.

At the reception desk

In the first instance, patients will usually go straight to the reception desk. The apparently mundane process of booking in is actually a little minefield. If patients' initial experience is negative or inefficient, the entire process of persuading them to receive (and pay for) dental treatment becomes that bit harder.

So, in the well-run practice, the receptionists have sufficient support and training so that patients are made to feel they are in good hands from the outset. Even more importantly, their details are accurately taken,

ensuring the records uplifted and the medical history completed are correct.

Waiting times

The patient is then usually asked to have a seat in the waiting room. Most reasonable people will not expect to be seen immediately, which is lucky since dentistry doesn't lend itself to punctuality.

We have all had a tooth which wouldn't come out, a crown which wouldn't fit or a child who wouldn't stop projectile vomiting (long story). However, smart dentists will have considered or even audited waiting times in order to identify and eliminate the most common reasons for running late. They know from bitter experience that, once all of the copies of *People's Friend* have been read twice, trouble usually follows.

So, the patient is called into the surgery, more or less on time, to be greeted by a dentist who is furnished with the correct clinical information. So far, so good. The patient is perhaps a little unhappy about the prospect of an imminent dental exam or treatment, but at least the situation hasn't been exacerbated by delays or administrative errors.

Managing expectations

Assuming that this is a first visit, an essential component of the ensuing consultation will be the clinical history. It may be that the patient will be a motivated, regular attender with low treatment needs. It goes without saying, however, that not every patient will fit this description. Obviously, the ethical practitioner must endeavour to address the needs and expectations of the individual. However, if insurmountable difficulties are identified and managed at the outset, then the risk of disappointment and conflict later on can be minimised.

For example, an edentulous patient may present holding a bag which contains the unsuccessful efforts of several previous practitioners. At this stage, it is only fair to politely explain that these dentures would

require to be examined in situ and, if it transpires that they cannot be improved upon, it may not be appropriate to try again.

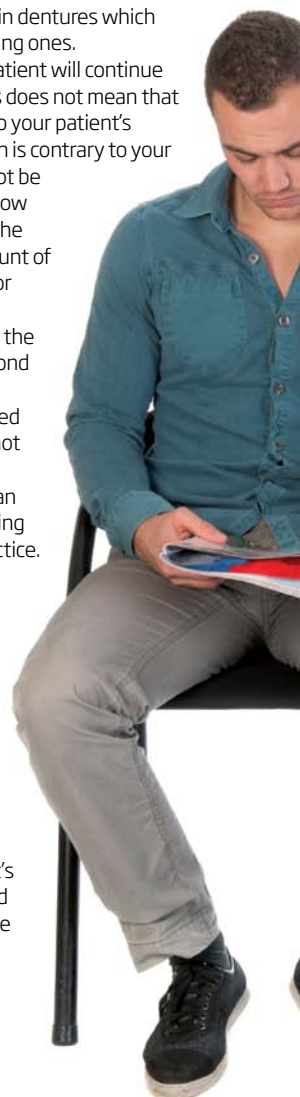
Patients who are so advised may decide to leave immediately. This outcome, while unpleasant, is probably preferable to the dispute which will follow once the patient has attended umpteen visits culminating in dentures which are no better than the existing ones.

In most instances, the patient will continue with their examination. This does not mean that you are obligated to agree to your patient's wishes. If a treatment option is contrary to your best judgement, it should not be attempted, irrespective of how desperately it is desired by the patient. Remember, no amount of 'consenting' will validate poor dentistry!

Of course, it may be that the treatment is viable, but beyond your ability. In such cases, a suitable explanation, followed by referral to a specialist is not only in the patient's best interests but might also be an efficient means of transferring the risk away from your practice. It's worth remembering, however, that an excessive reliance on referrals carries its own risks – you won't earn and you won't learn.

Planning and communication

Let's assume that at the conclusion of the examination a treatment plan is created. The patient's agreement should be based upon a complete knowledge of what is being proposed, together with risks, alternatives, costs etc. In fact, the GDC now expect



ROUTINE

"Many dentists know from bitter experience that, once all copies of People's Friend have been read twice, trouble usually follows"



all patients to be provided with a written treatment plan and cost estimate. Failure to properly inform patients at the consenting stage can lead to all sorts of problems, both in terms of patient complaints and compliance with regulatory requirements.

In all likelihood, your new patient will need to return for treatment. Here the process of risk management is resumed. The complaint-averse practitioner will confirm that the patient is still cognisant and content with the agreed treatment. The previous notes (which should have been carefully prepared at the previous visit) will be checked and bitewings will be reviewed before any intervention.

As treatment progresses, communication will continue. For example, if a filling turns out to be unexpectedly deep, warn that it may be sensitive post-operatively.

Reassure that this will probably be mild and self-limiting but, if not, you will be happy to provide further treatment. If the tooth is a little symptomatic the next day, the patient will not be on the phone to your receptionist in a state of alarm. If it remains completely asymptomatic, the patient will think you're a genius (though the tooth is probably non-vital!).

Audit

Finally, a great way of monitoring many of your systems of work is via clinical audit. This activity can effectively gauge aspects of your business such as waiting times or invoicing. It also helps to measure ongoing compliance with formal regulations in terms of, for example, record keeping and IR(ME)R. There can be little doubt that identifying and rectifying departures from efficient and good practice in this way helps to minimise the risk of problems, complaints and investigations. This, in turn, maximises the likelihood of getting a good night's sleep.

Doug Hamilton is a dento-legal adviser at MDDUS

TREATMENT

INSTRUMENT FAILURE



DAY ONE

Mr Z attends the dental surgery with a history of pain in a lower right tooth (LR6), especially on biting and chewing. The tooth had been filled two years previous. The dentist – Ms J – takes X-rays and notes irreversible pulpitis due to infection. She discusses options with the patient: root treatment or extraction. Mr Z opts for root canal treatment and an appointment is made for two weeks' time. The dentist also prescribes an antibiotic to reduce infection and ease the pain.



DAY 14

Mr Z attends for root canal treatment on LR6. Pre-treatment X-rays are taken and Ms J administers a local anaesthetic. She proceeds to remove the MOD restoration and then the pulp using a barbed broach. Next she employs a lentulo spiral filler to spin Ledermix into the canal. The instrument fractures and part of it is retained in the canal. Ms J uses another spiral filler to try to remove the fragment but this is unsuccessful. She then abandons the procedure and the tooth is dressed with sedanol. A second radiograph is taken confirming the presence of the fractured instrument and Ms J informs the patient (though this is later disputed). Mr Z is given another prescription for antibiotics and an appointment is made for him in a week's time.



DAY 72

Two months on from his last appointment Mr Z phones the dental surgery to say he has not heard from the dental hospital. He is now suffering persistent pain in LR6 so Ms J re-refers and an urgent appointment is arranged. Mr Z attends the dental hospital and is treated by Dr K who removes the amalgam filling and locates the fractured instrument but fails to remove it. A second attempt is made one month later but also fails. The only remaining option is extraction of the tooth.



DAY 41

Mr Z returns to the surgery complaining of discomfort though not severe pain in the tooth. Ms J makes a routine, non-urgent referral which is sent by post but not received at the dental hospital.



DAY 22

A second attempt is made to remove the fractured instrument from the canal but this is again unsuccessful. The patient later alleges that Ms J told her that there should be no problem leaving the broken instrument in the tooth as it is sterile. She places an MOD amalgam restoration in the tooth and tells Mr Z she will refer him to the dental hospital if there is persistent pain.

THREE months later Ms J receives a letter of claim from solicitors acting on behalf of Mr Z alleging clinical negligence in the treatment of his tooth. A report has been produced by a restorative dentist that is critical of Ms J's treatment of the patient. MDDUS advisers and solicitors review the report and all associated correspondence along with the patient records.

It transpires that Ms J's record keeping is very poor. There are no written treatment plans or references in the notes to the radiographs taken. No note can be found to refute Mr Z's claim that he was not informed of the instrument failure until a follow-up

appointment. The expert is also critical of the dentist's suggestion that the tooth would be okay because the instrument had been sterile.

Further discussion with Ms J regarding the paucity of notes also reveals that she did not use an apex locator to estimate working length. There is no record of use of rubber dam or any instrumentation or irrigation prior to the use of the spiral filler. This casts doubt on the actual standard of root canal treatment.

Considering these weaknesses it is agreed that the claim would be better settled. An amount is negotiated based on the cost of a single implant.

Key points

- Ensure that full and complete contemporaneous records are kept of treatment plans and discussions with patients.
- Memory cannot be relied upon in legal defence.
- Be open and up-front with patients when complications occur.

OUT THERE

THEBAN THROBBING A good dentist was clearly hard to find in Thebes 2,500 years ago. Royal Brompton Hospital scientists who CT scanned Egyptian mummies found one adult male had potentially life-threatening dental abscesses. In a final insult, the embalmer botched the afterlife preparation, leaving bits of brain and a broken spatula in his skull.

TRIGGER TEST The noise of dental drills and the scraping of metal instruments may trigger anxiety in some patients. Researchers in Japan say phobic patients' brains react differently to the sounds. It's hoped the findings will help develop ways of treating dental fear, such as cognitive behaviour therapy. Source: *The Guardian*

WHEN IN ROME Urine was a popular tooth-whitening treatment in Ancient Rome, with Portuguese pee considered the best for the job. The Egyptians were thought to be the first tooth-whiteners around 4,000 years ago, using a paste of ground pumice stone mixed in wine vinegar.

GO BANANAS Eating 50 bananas exposes you to the same amount of radiation as a dental X-ray. Each fruit contains 0.1 microsieverts while an intra-oral X-ray has five microsieverts. By comparison, a chest CT scan has the equivalent radiation of eating 70,000 bananas.



NAME THAT BITE

Stumped? The answer is at the bottom of the page

PHOTO: MANFRED KAGE/SCIENCE PHOTO LIBRARY

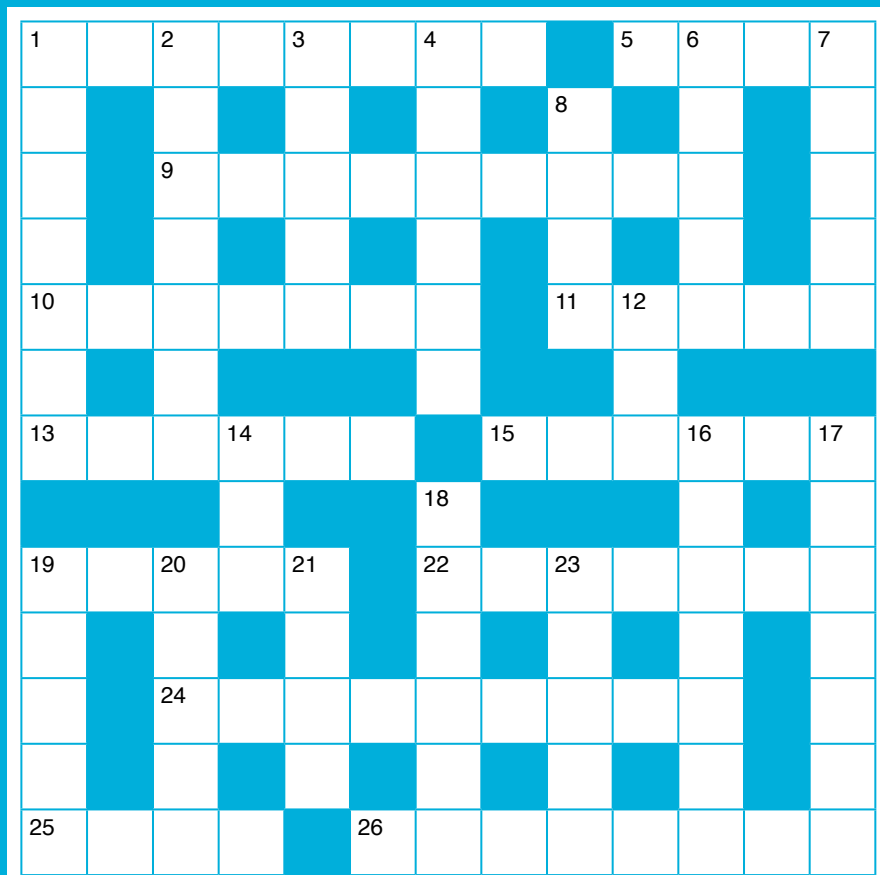
CROSSWORD

ACROSS

1. Branded gingivitis treatment (8)
5. Closed sac (4)
9. Thin foils for occlusal adjustments (9)
10. Under enamel (7)
11. Indirect filling (5)
13. Away from the centre of the body (6)
15. Portion of dental bridge substituting absent tooth (6)
19. Branded temporary filling material (5)
22. Towards the crown (7)
24. Branded sensitive toothpaste (9)
25. Post and _____, restoration (4)
26. Relating to contact between teeth and jaw (8)

DOWN

1. Obscured (7)
2. Begrudges (7)
3. African antelope (5)
4. Prefix, time before as in not today (6)
6. Country bumpkin (5)
7. Striped or brindled cat (5)
8. Braxton, US soul diva (4)
12. Grandmother (3)
14. Prefix, three (3)
16. Do they hang around with tailors, soldiers and spies? (7)
17. Military rank (7)
18. Imitative of natural sounds (6)
19. Pertaining to local government (5)
20. Part of helmet covering face (5)
21. Sharp taste (4)
23. Majestic (5)



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

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