Sound Bite

ISSUE 11

BITING FIT

MAJOR ORIANNE MOXON TALKS ABOUT LIFE IN THE DEFENCE DENTAL SERVICES

ALSO INSIDE

AN MDDUS PUBLICATION

MDDUS

Welcome to your SoundBite

AFTER years of hard work, it's a great feeling to finally graduate and enter the world of work. As dental professionals, we never really stop learning and there are many opportunities for us to build our knowledge and skills throughout our careers. One key element of that is CPD. Some may question its relevance but my article on page 4 explores some of the reasons why continuing professional development is more important than ever.

Another great opportunity to expand your skill set is by joining a professional organisation. There are numerous options, and our article on page 5 considers the merits of joining the Faculty of General Dental Practice UK.

The old saying goes that "an army that cannot bite, cannot fight". Armed forces dentist Orianne Moxon talks about her work caring for military patients around the world on page 12.

With nearly half the UK population suffering from gum disease, the need for periodontists is increasing. Our career article on page 8 looks at what it's like to work in this challenging specialty.

Being a good dentist is about more than addressing patients' clinical needs. MDDUS risk adviser Cherryl Adams highlights the importance of listening and communicating effectively on page 6. A recent court case has changed previously held views on the definition of informed consent. MDDUS dental adviser Claire Renton explains the changes on page 10. The GDC has renewed its focus on raising concerns about children and vulnerable adults – find out more on page 7.

Our case study on page 14 looks at claims of dental neglect over an eight-year period.

• **Sameera Teli**
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DENTISTS MUST BE CLEAR ON TREATMENT COSTS

A RECENT report from the Parliamentary and Health Service Ombudsman urged dentists to be clearer with patients about what they charge to help avoid confusion about the cost of treatment.

It identified 27 cases over the last two years where confusion about dental charging was an issue and found that the current system is confusing for both patients and dentists. Furthermore, it found that some practitioners fail to share treatment plans with their patients, despite an obligation to do so.

MDDUS dental adviser Doug Hamilton suggests that, while the vast majority of dentists would never intentionally misinform a patient over treatment options and costs, there seems to be an increasing number of complaints arising from fee-related misunderstandings.

"Many of these disputes can be avoided by the provision of a cost estimate to patients prior to dental treatment being provided," says Hamilton.

"Practitioners must also be sure to clarify whether charges are private or on the NHS and ensure patient interests are put first when considering treatment options."

DENTAL FACULTY GUIDANCE NOW OPEN TO ALL

ALL dental professionals can now access guidance and standards produced by the Faculty of General Dental Practice (UK).

The Open Standards Initiative aims to raise standards in the profession and improve patient care by allowing non-members to view the full text of information documents online.

The Faculty hopes removing the pay-wall that previously blocked access will increase their influence on the profession and wider dental health.

Their stated aim is to "positively influence oral health through education of the dental profession and the provision of evidence-based guidance," but Dean Dr Trevor W Ferguson accepted their guidance would have "no impact if people do not have access to them."

He said: "The Faculty has long recognised that there is a disconnect between its aims in producing the standards guidance and the method it uses to disseminate them.

"[Our] standards and guidance will not have the influence on the profession and therefore the nation's oral health that they otherwise could while they remain behind a pay-wall."

The initiative is being rolled out over two phases.

Under phase one, three of the Faculty's publications have been made available online free of charge. They are *Selection Criteria for Dental Radiography, Clinical Examination and Record Keeping* and *Antimicrobial Prescribing for General Dental Practitioners*. These will soon be followed by updated versions of *Standards in Dentistry* and *Guidance for the Maintenance of Natural Rubber Latex Allergies*. Phase two will be launched later this year and will see the release of e-book versions of FGDP standards and also a mobile app. Hard copies will continue to be available for sale.

More information about the initiative is available at **http://www.fgdp.org.uk/osi/open-standards-initiative.ashx** Non-members can login with the username and password "openstandards".

DROP IN PRIVATE DENTAL COMPLAINTS

THE number of complaints about private care handled by the Dental Complaints Service (DCS) dropped by more than 40 per cent last year, new figures show.

The DCS processed 1,068 complaints in 2014 compared to 1,876 the previous year – a drop of 43 per cent.

The large decrease is being attributed to the introduction of a new complaints management system last May which has improved the way complaints are classified and helped identify those which fall outside the organisation's remit.

In addition to complaints, the DCS dealt with 1,012 enquiries between May and December 2014, with an annual total of 7,718 telephone calls.

The most common treatment complaints related to dentures (18 per cent), followed by crowns (17 per cent) and fillings (11 per cent).

Complaints about implants and bridges each made up nine per cent, while braces and root treatment made up eight per cent each.

The proportion of complaints about dentists dropped slightly from 96 per cent in 2013 to 93 per cent in 2014. There was a small rise in complaints about clinical dental technicians over the same period, from 1.5 per cent to three per cent, and for dental technicians, from one per cent to two per cent. Complaints about dental nurses rose from 0.15 per cent to 0.5 per cent.

The largest number of complaints was made in the south east of England, accounting for 24 per cent of the total. London came second with 19 per cent of complaints, followed by the south west of England on 11 per cent and the north west on nine per cent. In contrast, only 0.5 per cent of complaints were made in Yorkshire and Humber. Nine per cent of complaints were made about care in Scotland while three per cent related to Wales and 0.5 per cent in Northern Ireland.

Head of Service at the DCS Hazel Adams said: "We're now in our ninth year and we're continuing to adapt and improve the service that we deliver.

"The DCS uses a three-step service to assist patients and dental professionals to come to a mutually agreed solution and our team of specialist volunteer panel members and trained staff ensure that we offer a high quality service that helps facilitate mutually acceptable solutions for both parties."

Find out more about the DCS at **www.dentalcomplaints.org.uk**

DENTISTS FEELING "DISSATISFIED WITH LIFE"

DENTISTS are almost twice as likely as the general population to feel dissatisfied with life, according to research from the British Dental Association.

Figures also suggested general dental practitioners (GDPs) who mainly carry out NHS work are less happy than those who mainly do private work.

A total of 481 community dentists and 903 GDPs responded to the survey in June and July 2014, with results published in the report *Is there a well-being gap among UK dentists?*

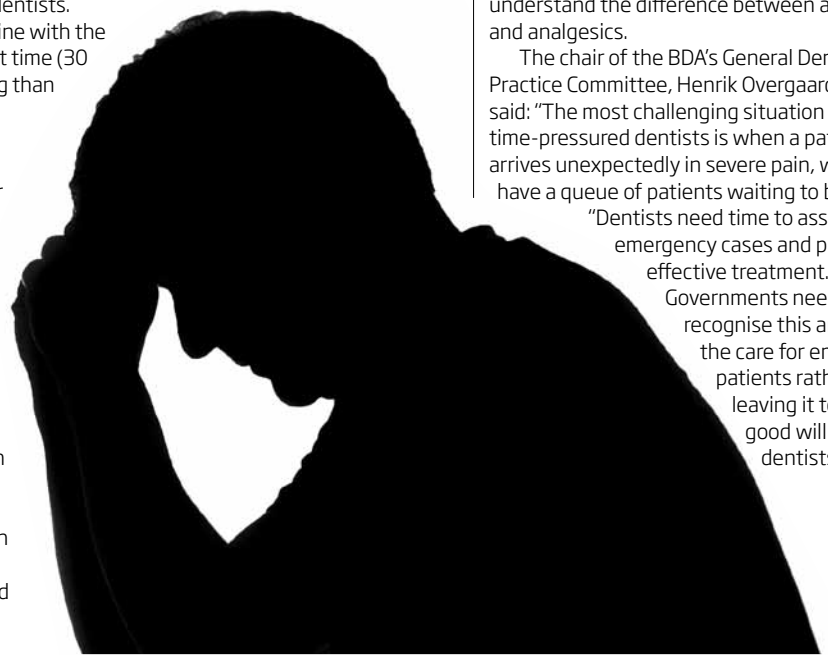
Almost half of the GDPs and community dentists surveyed (47 per cent) reported low levels of life satisfaction with a similar proportion (44 per cent) reporting low levels of happiness. Almost six out of 10 GDPs said they experienced high levels of anxiety during the day compared to 55 per cent of community dentists.

Among associates, stress levels increased in line with the number of hours worked. Those who worked part time (30 hours or less) reported higher levels of well-being than those working full time.

Four out of five GDPs perceived their general health as "good", with almost 40 per cent describing it as "very good". Dentists aged under 35 rated their health most highly, but this feeling diminished gradually with age.

The report concluded that there is indeed a "well-being gap" between the dental profession and the general population. This is consistent, it states, with wider research suggesting UK dentists are exposed to "occupation-specific stressors which put them at risk of high levels of work-related stress".

The BDA said it plans to build on the research by examining further the relationship between working conditions, high job stress and mental well-being in dentists. "A key aim of this research will be to develop effective strategies for preventing high levels of work-related stress and reducing levels of burnout among dentists," the report added.



DENTAL CONSENSUS ON TACKLING ANTIMICROBIAL RESISTANCE

A CONSENSUS report setting out a comprehensive blueprint to help dentists play their part in the global fight against antimicrobial resistance (AMR) has been launched by the BDA.

The report summarises the findings of an event hosted by the BDA last year to consider how best to conserve the effectiveness of existing antibiotics and overcome barriers to reduce inappropriate prescribing. The meeting brought together antimicrobial specialists, educators, defence organisations, the Faculty of General Dental Practitioners, the Association of Clinical Oral Microbiologists and the Cochrane Oral Health Group, as well as representatives from government and the pharmacy, medical and veterinary professions.

The consensus report points out that not only is cross-professional and international collaboration required but patients and the public also need to be made aware of AMR and understand the difference between antibiotics and analgesics.

The chair of the BDA's General Dental Practice Committee, Henrik Overgaard-Nielsen, said: "The most challenging situation for time-pressured dentists is when a patient arrives unexpectedly in severe pain, when you have a queue of patients waiting to be seen.

"Dentists need time to assess these emergency cases and provide effective treatment. Governments need to recognise this and fund the care for emergency patients rather than leaving it to the good will of dentists."

A LIFETIME OF LEARNING

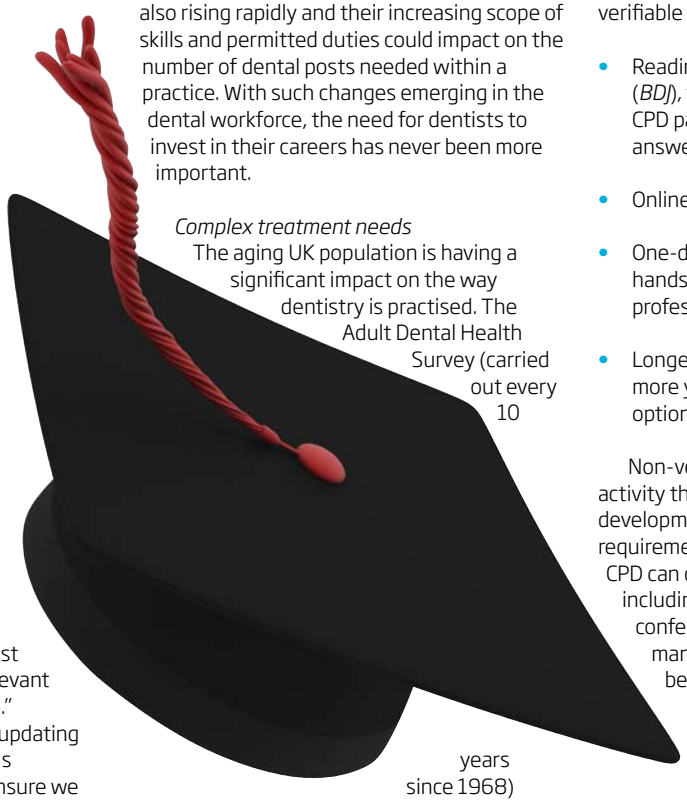
All dentists must undertake continuing professional development throughout their careers. But is it really worthwhile? *SoundBite* editor Sameera Teli investigates

I WILL always remember the wonderful feeling of graduating and entering the dental profession, a prospective future of building my knowledge and skills ahead of me. Foundation training provided a year of exponential learning and invaluable experience. However, as the level of learning began to taper, I felt the need to explore other opportunities to further my knowledge and experience as a dentist.

Key to this is continuing professional development (CPD). The concept has a long history within dentistry but was only formalised by the General Dental Council in 2002. The Lifelong Learning Scheme required the completion of 250 hours of CPD over a five-year period as a compulsory part of GDC registration.

The GDC defines CPD as "lectures, seminars, courses, individual study and other activities that can be reasonably expected to advance your professional development as a dentist or dental care professional and is relevant to your practice or intended practice."

The principle behind continually updating our professional knowledge and skills throughout our working lives is to ensure we always provide patients with the best care we can. The best way to approach CPD is to focus on the outcome, of how it can help us in our work, rather than treating it as a mere box-ticking exercise.



The need for CPD

Some may question its merits, but a number of recent changes in dentistry reinforce the need for effective learning that is carefully chosen to add real value to our professional practice.

Rising complaints

Patient complaints have been rising steadily in recent years. In 2014 the GDC reported a 110 per cent increase over the previous three years, a trend that has been largely blamed for the 64 per cent rise in the Annual Retention Fee. The regulator even went so far as taking out a newspaper advert last summer to advertise their Dental Complaints Service which covers private dentistry. In these increasingly litigious times, relevant and effective CPD is a vital tool for dentists.

Greater competition

With more dental graduates entering the jobs market than ever before, both from the UK and overseas, competition for posts is increasing. The possibility of dentists being unemployed has only become a recent reality. The number of dental therapists entering the workforce is also rising rapidly and their increasing scope of skills and permitted duties could impact on the number of dental posts needed within a practice. With such changes emerging in the dental workforce, the need for dentists to invest in their careers has never been more important.

Complex treatment needs

The aging UK population is having a significant impact on the way dentistry is practised. The Adult Dental Health Survey (carried out every 10 years since 1968) revealed recently that the proportion of edentulous adults is declining. As oral health habits improve, people are holding onto their teeth for much longer than before. This has led to a growing patient base presenting with increasingly sophisticated and complex treatment needs.

Increasing patient expectations

The culture within dentistry is changing and patients' expectations regarding outcomes are growing, with many seeking increasingly complex treatments or procedures. While this presents an opportunity for us to expand and improve our skill base, we must always know our limits and work within our individual competence, referring to a specialist where appropriate.

Types of CPD

CPD can be either verifiable or non-verifiable. The GDC states that, of the 250 hours required over a five-year period, at least 75 hours should be "verifiable", supported by evidence and ideally carried out in recommended topic areas. More information is available in the GDC's CPD guidance booklet - **tinyurl.com/pajgapl**

Verifiable CPD is available from professional bodies such as the British Dental Association (BDA), universities, the Royal Colleges and the Faculty of General Dental Practitioners.

Some of the main forms of achieving verifiable CPD include:

- Reading journals. The *British Dental Journal* (*BDJ*), for example, provides two verifiable CPD papers per issue, available by answering set questions.
- Online/e-learning courses
- One-day courses – these can offer hands-on experience to enhance professional skills
- Longer training courses, often of one or more years, can be undertaken, with options for hands-on or distance learning.

Non-verifiable CPD refers to any relevant activity that advances your professional development but does not fulfil all of the GDC requirements for verifiable CPD. Non-verifiable CPD can come from a vast array of activities including peer reviews, attending conferences, and clinical audit. They are many and varied and some will be of better value than others.

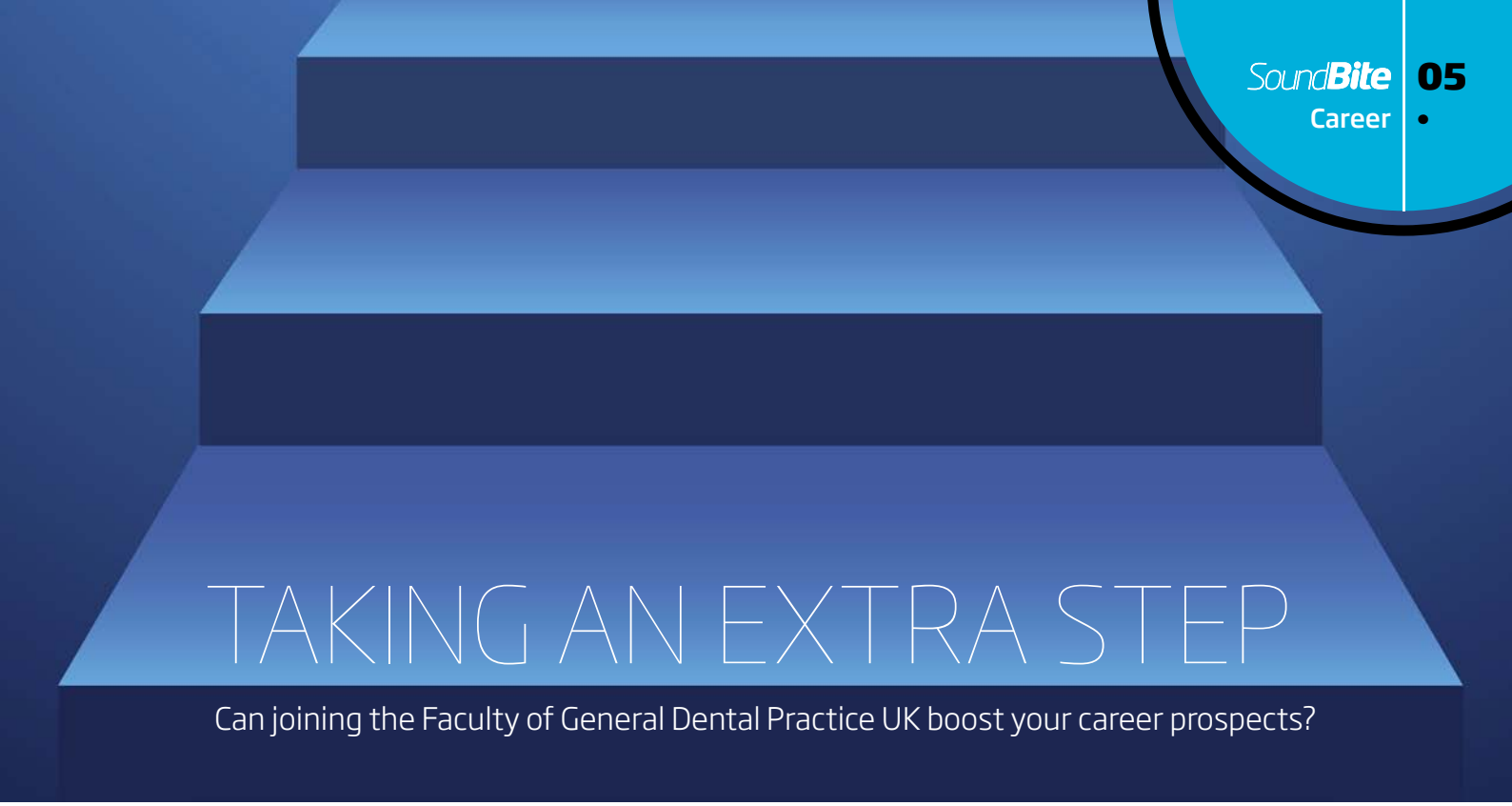
Personal reflections

As a relatively recently qualified dentist with a strong interest in general practice, I wish to build on what I have learned in the early years, and strive to achieve the highest standards.

Currently I am in the middle of an FGDP(UK) Diploma in Restorative Dentistry. The strong evidence-based approach and hands-on teaching has helped develop positive changes in my management and approach to patients and I hope will continue to do so.

Dentistry is a dynamic and continually evolving profession which deserves a lifelong learning approach, one that allows us to remain up-to-date with the latest developments and deliver the best patient care.

Sameera Teli is a dentist and editor of SoundBite



TAKING AN EXTRA STEP

Can joining the Faculty of General Dental Practice UK boost your career prospects?

COMPETITION for dental jobs is becoming increasingly fierce as the number of graduates looking for training posts continues to rise. Standing out from the crowd is more important than ever – so how can trainees improve their prospects?

One available option is to join a professional organisation. There are a number that are relevant to dentists (including the Faculty of Dental Surgery), but one of the most popular is the Faculty of General Dental Practice (FGDP(UK)).

Formed in 1992, it is part of the Royal College of Surgeons (RCS) and is made up of 21 divisions based across the UK. It looks after the continuing professional development (CPD) training of 5,000 dentists and dental care professionals working in general practice. It also publishes a range of professional standards and guidance documents (available free of charge online to non-members under the Open Standards initiative).

The Faculty advertises itself as being "run by primary care dentists for primary care dentists", and pledges to "support you throughout your career in general dental practice, from dental school to vocational training and beyond", adding: "The FGDP(UK) is an organisation that can make a real difference to your career."

Membership benefits include access to the quarterly *Primary Dental Journal*, and online resources including the RCS Athens learning portal. Training courses (with member discounts of up to £1,000) are varied, from short masterclasses in periodontics or facial aesthetics, to two year postgraduate diplomas in implant dentistry or restorative dentistry.

There are learning and networking opportunities at local and national events – most Faculty divisions run CPD events with guest speakers, as well as study days and conferences in larger areas.

The Faculty also campaigns on behalf of members, seeking to influence developments in primary care dental regulation, standards and policy.

How to join

Dental students in their fourth and fifth years of study are eligible to join the Faculty for free as an e-ssociate member. Charges vary for others depending on date of qualification and postgraduate qualifications. For example, associate membership – open to registered dentists within three years of graduation – costs £83. "Associate +3" membership – for dentists qualified at least three years who do not hold an approved postgraduate diploma – costs £218.

There are a number of routes to full membership but the most common is by passing the Membership of the Joint Dental Faculties (MJDF). More than 1,800 people sat the exam in 2014 and those who pass can use the letters MJDF after their name.

The Faculty states: "The MJDF is the only examination of its type that recognises that the vast majority of dentistry takes place in the primary care setting, and examines you on the skills and knowledge you actually use in practice. Some skills that bridge the divide between primary and secondary care are also tested, making the MJDF a good stepping stone towards specialism. Wherever your career takes you, the MJDF is a relevant test of your skills and knowledge.

"With the letters MJDF after your name, you are able to demonstrate that you have passed an internationally recognised examination of your competence in practice."

The exam consists of two parts at locations throughout the UK and internationally, although the primary venues are Leeds and London. Part one consists of a three-hour written exam while part two is a more practical objective structured clinical examination (OSCE) to assess competence and application of knowledge, alongside a structured clinical reasoning component assessing communication skills and application of knowledge.

Sittings are held annually: part one is at the end of March/April (costing £522) and part two (£660) is held end of May/June and late November. There is an extra £50 charge for the submission of a portfolio evidencing skills in five core clinical and professional areas, clinical audit, a CPD log, personal development plan and an up-to-date CV.

Those who pass the MJDF can opt to become a member of the Royal College of Surgeons and its two dental faculties. FGDP members can therefore access advice and support on primary care dentistry as well as support on entering and practising in secondary care from the Faculty of Dental Surgery.

Highest standards

West Midlands dentist Kaushik Paul passed the MJDF exam and is now an MJDF tutor as well as the FGDP(UK) representative on the Advisory Board for Foundation Training in the UK.

He praised the Faculty, saying: "Being part of the FGDP(UK) has allowed me to strive for excellence and quality, attributes that give me great personal satisfaction and my patients the surety of the very highest standards of practice.

"The Faculty has allowed me to meet fellow colleagues through its divisional meetings, and to share ideas and thoughts. But it was the ability to contribute back to the profession that made it even more special."

The Faculty has noted other positive feedback from members. London dentist Reena Wadia said: "Divisional study days offer a great opportunity to listen to the experts and network with like-minded dental professionals." Fellow London clinician Radhika Chopra summed up her experience by saying: "If you are looking to progress in your career, the FGDP(UK) will be your helping hand."

For more information, visit the FGDP website at: www.fgdp.org.uk

LISTEN AND UNDERSTAND

Good communications skills are crucial to building strong patient relationships

THE move from final year dentist to vocational trainee can be quite an adjustment to make. Meeting your patients forms a significant part of this transition. Forging appropriate relationships and building trust and rapport can ease the initial stress.

Understanding your patients and adapting your communication style appropriately can help dramatically with this, as well as allowing you to identify and manage expectations – a key factor in patient satisfaction.

Interpersonal aspects of care

In practice, the clinical aspect of the dentist-patient relationship is a clear focus while the "softer" aspects of providing care can often be overlooked. As in most healthcare settings many patients visit their dentist with a certain degree of trepidation. They can be nervous, stressed and worried, and in this heightened emotional state can be more sensitive to the interpersonal aspects of the consultation.

At MDDUS we often advise on situations where patients have had a consultation that has seemingly gone well, with all of their clinical needs addressed, but something in the dentist's or perhaps receptionist's approach has triggered a complaint.

One recent complaint received on behalf of an MDDUS member involved a mother and her son who had presented for routine check-ups over a period of two years. Both had very good oral hygiene and as a result appointments had been handled quickly and without incident. It was with some surprise, therefore, when the dentist received a letter from her complaining of a "rushed and impersonal service".

The patient had felt the dentist was not interested in them as patients, but only in getting them in and out the door as quickly as possible. Indeed, the mother said she had been keen to discuss braces for her son, but felt there was never an opportunity to open up a discussion with the dentist as they were dealt with so swiftly. The dentist always finished his consultation with: "All fine. Make an appointment at reception for six months". He then turned away from the patient as they left the chair and room. The patient felt she had made it quite clear that she was poised to ask questions, but felt that the dentist had already psychologically moved on to the next patient and that this was her being "dismissed".

This demonstrates where the functional aspects of a consultation have been fulfilled but the personal needs of the patient have somehow or other not been met. Such personal needs might include feeling: welcome, understood, comfortable, secure, and listened to. The *NHS Constitution* and *The Charter of Patients' Rights and Responsibilities* spell out the importance of communication, participation, respect and compassion and also emphasise the need for feedback and patient participation.

Active listening

Building trust and rapport with patients can help fulfil these areas and a key aspect of this is simply listening. Listening can be difficult to do well, particularly in a time-pressured environment or when you are new to practice.

Consider these points:

- **Listen through the patient's words** for the key themes, needs and messages.
- **Stay in the interaction:** pay full attention to the patient.
- **Be aware of stereotyping** and making assumptions.
- **Observe the non-verbal communication**: what's their body language saying?
- **Give signals to show you're listening**: eye contact, nods, encouraging noises.
- **Use appropriate questioning:** clarification, exploring, interpreting.
- **Summarise** what the patient is saying and reflect it back to them.
- **Avoid jargon:** use language which is easily understood; use diagrams.
- **Agree a collaborative way forward**: reasoning, methods, timescales, reviews.
- **Encourage feedback:** seek feedback and encourage questions ("Is there anything else…?")

All of this can equally be applied to the dental team as well as patients. Information gleaned from team members can greatly inform your interaction with patients. An experienced nurse can be invaluable and give the newly qualified dentist a helpful steer with patient knowledge and associated behaviours – which patient needs a bit more time or information, who is particularly nervous, or even simple things that just smooth an interaction like how a patient likes to be addressed.

GDC principles

Patients can find healthcare interactions confusing and the volume of information overwhelming, making it difficult for them to question or seek clarification on treatment. Costs can also be an issue for those facing financial pressures. Reluctance to question and feedback can trigger issues around key risk areas including: communication, consent, treatment planning and diagnosis.

The first three GDC principles are:

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

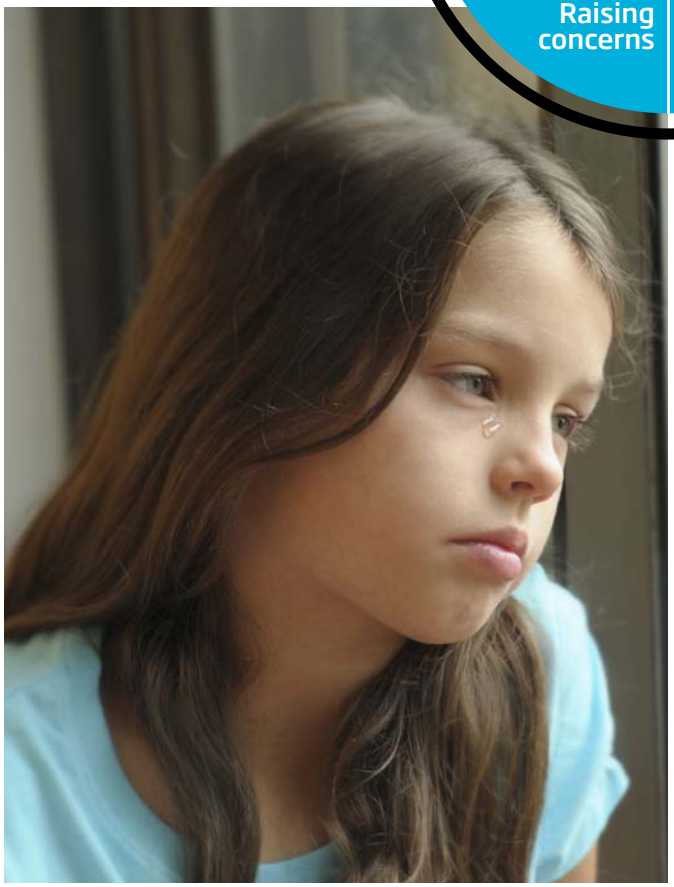
These are all heavily dependent on effective communication. Listening well and employing clarity and transparency with your patients will aid your communication and allow you to create a fuller picture, which will in turn allow you to adopt an individualised approach. A holistic view can be developed of a patient's overall health, reactions to treatment proposals and any concerns they may have – this will ultimately allow you to tune in to what is important to each patient and encourage them to feed vital information back to you.

Enabling this clear and open communication can lessen your risk and make interactions more positive and productive for the patient and for you.

Cherryl Adams is a risk adviser at MDDUS

SPOTTING THE SIGNS

Safeguarding children and vulnerable people have been made key learning areas this year. What does this mean for dentists?



HUNDREDS of children and vulnerable people undergo dental treatment across the UK every day, making dentists ideally placed to look out for signs of abuse or neglect.

All dentists – including trainees – have a professional duty to raise concerns, but deciding if and when to take action can prove challenging for even experienced clinicians. Despite the difficulties it presents, suspicions should never be ignored. Failing to act can have serious implications for those in harm's way and dentists could face sanctions from the General Dental Council.

Indeed, the GDC has renewed its focus on this area recently by making safeguarding children, young people and vulnerable adults key learning areas, including them as recommended continuing professional development (CPD) topics.

The regulator said the move is designed to increase awareness of the issues "so that all dental professionals feel confident and equipped to raise any concerns about abuse or neglect of vulnerable people".

The GDC's guidance *Standards for the Dental Team* states: "You must raise any concerns you may have about the possible abuse or neglect of children or vulnerable adults. You must know who to contact for further advice and how to refer concerns to an appropriate authority such as your local social services department."

It adds: "You must find out about local procedures for the protection of children and vulnerable adults. You must follow these procedures if you suspect that a child or vulnerable adult might be at risk because of abuse or neglect."

One useful resource is the *Child protection and the dental team* (CPDT) website which offers a range of advice and learning materials. Although aimed mainly at dental teams providing primary care in England, much of the information applies across the UK and there is supplementary information for practitioners in Scotland and Wales.

CPDT offers practical advice on recognising and responding to various forms of abuse. For example, orofacial trauma occurs in at least half of children suffering from physical abuse, including bruising, abrasions and lacerations, eye injuries and intra-oral injuries. There is a list of useful yes/no questions that can be kept in the surgery (either printed out or incorporated into electronic records) to act as a prompt.

These are:

- Has there been delay in seeking dental advice, for which there is no satisfactory explanation?
- Does the history change over time or not explain the injury or illness?
- When you examine the child, are there any injuries that cannot be explained?
- Are you concerned about the child's behaviour and interaction with the parent/carer?

If the answer to any of these questions is "yes", dentists are advised to "discuss with a senior colleague and follow local child protection procedures". If all the answers are "no" then it says the patient can be diagnosed and treated as normal.

CPDT encourages clinicians to ask the child/vulnerable person about the cause of any injuries and to allow them to talk if they volunteer information about abuse. It is advised to avoid asking leading questions and to respond calmly and kindly with a non-judgmental attitude.

It adds: "A child who makes a disclosure of abuse should always be taken seriously. If requested to keep a secret, you should not do so but should explain that you may have to share information, but will explain with whom and when it will be shared."

The national Childsmile oral health initiative operates in Scotland and delivers training courses which cover child protection issues. Its website also links to the Scottish Government's Getting It Right For Every Child (GIRFEC) programme which includes the Named Person system which aims to make a named person available to offer advice and support to every child from birth to age 18.

The Scottish Dental Clinical Effectiveness Programme (SDCEP) has published guidance *Prevention and Management of Dental Caries in Children* which advises on child protection, including the issue of dental neglect. When children or vulnerable patients present with a large amount of dental caries, it recommends practitioners encourage the parent/carer to take responsibility and involve them in the care planning progress, offering advice and support where appropriate.

Where a parent/carer fails to comply, it states this may be indicative of dental neglect, but cautions: "Reaching this conclusion will call for particularly careful judgment. "

If you have concerns but are unsure of how to proceed, it can be useful to discuss the issue with a colleague or an MDDUS adviser. Often there are concerns that raising the alarm will result in a patient complaint or even aggression towards practice staff, but remember that the main concern should always be the patient's best interests, particularly when it involves a child or vulnerable person.

Useful links:

- Child protection and the dental team: **www.cpdt.org.uk/index.aspx**
- Childsmile: **tinyurl.com/nvqx9x5**
- SDCEP – *Prevention and Management of Dental Caries in Children*: **www.sdcep.org.uk/published-guidance/caries-in-children**

Joanne Curran is an associate editor of SoundBite

Is the specialty of periodontics for you?

SUPPORTING ROLE

AN estimated 45 per cent of UK adults suffer from moderate to severe periodontal disease, according to the most recent Adult Dental Health Survey[1]. Extrapolating from this number the authors of a 2014 *BDJ* article estimated that the number of specialists required to meet the periodontal treatment needs of the UK population was around 2,200 at minimum[2]. But in 2014 there were only 318 dentists on the GDC specialist list in periodontics.

"There is clearly, therefore, a need for an increased number of specialists in periodontics," they concluded.

No doubt demand will only grow as the number of people over age 65 increases and advances in dental treatment mean that more people remain dentate into old age and therefore potentially susceptible to gum disease. All these factors make periodontology an important and promising career option. It is already a discipline widely regarded as the foundation to restorative dentistry.

Periodontology is the study of the specialised system of hard and soft tissues that support the teeth and maintain their position in the jaw – otherwise known as the periodontium, which includes the gingiva (gums), alveolar bone, cementum and the periodontal ligament.

Periodontists specialise in the prevention and treatment of diseases of the periodontium. All dentists are trained in the diagnosis and treatment of periodontal disease; however, severe or complex cases (BPE 4) should be treated by an appropriately trained individual and may be referred to a periodontist, who has undertaken recognised postgraduate training to develop special expertise in this area. The field comprises a range of management modalities, from non-surgical treatment of periodontitis to surgical treatment, including mucogingival surgery for recession defects. It also includes additional training in implantology to offer dental implants as an option to replace missing teeth.

Entry and training

Periodontics is one of 13 specialties where practitioners in the UK must be registered on a GDC list in order to be called a specialist. To become a specialist you must complete a training programme approved by the GDC, leading to the award of a Certificate of Completion of Specialist Training (CCST). A formal curriculum, set by the GDC and delivered by postgraduate centres in conjunction with deaneries, outlines the required training and methods of assessment of specialty trainees in periodontics.

The minimum requirement for entry to specialty training in periodontics is two years of postgraduate foundation training or equivalent, which may include a period of vocational training (VT) and also a period of training in secondary care in an appropriate specialist environment. Successful foundation year training might include membership of the dental faculty of one of the UK Royal Colleges of Surgery but this is not essential and candidates may be able to demonstrate competence in different ways. Some training in surgical dentistry would be considered desirable.

To qualify as a specialist in periodontics normally requires three years (4,500 hours) training whole-time or the agreed equivalent in a part-time programme. The programme content should be apportioned approximately as 60 per cent clinical, 25 per cent academic and 15 per cent research. Training may be flexibly delivered through a variety of methods including a taught master's degree programme or through a workplace-based programme (specialty practice or hospital-based training). In either case it remains mandatory for trainees to demonstrate certain minimum outcomes in the requisite skills with tracking of the learning process.

Training will include:

- guided theoretical learning
- validated self-directed and independent study
- technical skills development through the use of systematic simulation laboratory exercises
- clinical skills development through supervised clinical practice
- research exposure through participation in a research project (clinical, experimental or literature research) which is reported formally in a thesis or equivalent written report, or as a manuscript prepared for submission or as a published paper.

Specialty training takes place within programmes approved by a relevant postgraduate deanery and each trainee will tend to have a designated lead trainer (educational supervisor) who will co-ordinate the training and assessment throughout the period.

The job

Periodontists often treat more problematic periodontal cases such as severe gum disease or patients with a complex medical history.

Periodontists offer a wide range of treatments, such as root surface debridement, pocket reduction surgery, regenerative procedures, root resections, crown-lengthening surgery and mucogingival surgery. In addition, periodontists are specially trained and well suited in the surgical placement of dental implants.

Helpful links

More information on periodontics as a career is available via the following links:

- British Society of Periodontology: **www.bsperio.org.uk**
- Curriculum for specialty training in periodontics: **goo.gl/tnF6HK**

1 Steele, J. & O'Sullivan, I. (2011) Adult Dental Health Survey 2009. The Health and Social Care Information Centre.
2 Griffiths G S & Preshaw PM. Manpower planning in periodontology – how many specialists do we need? BDJ 2014; 217: 399-402

Q&A

Dr Manoj Tank, 3rd year specialty trainee registrar in periodontology at Guy's Hospital

• What attracted you to a career in periodontology?
I was initially inspired by a teacher of mine whilst at the University of Bristol who allowed me to assist him during some pocket reduction and root resection surgicals. This opened up the specialty as more than just root surface debridement. Once I truly understood that periodontology encompassed both non-surgical and a variety of interesting surgical procedures, I knew this would be perfect for me.

• What do you enjoy most about the specialty?
My favourite aspect of periodontology is the delicate soft tissue surgery. There is so much skill involved in how we raise minimally invasive flaps and how we can manipulate soft tissue to do exactly what we want it to do. I also thoroughly enjoy periodontal plastic surgery for treating recession defects, whether that is via free gingival grafts, connective tissue grafts or even with the use of acellular dermal matrix grafts for multiple recession defects.

• What do you find most challenging?
The challenge in this field is not always mastering your clinical skills, especially when it comes to your regular 'bread and butter' non-surgical treatments. You have to train yourself (no one can do this bit for you) to become an effective life coach for most of your patients. Getting them to understand they have periodontal disease in the first place can be a challenge as it is typically a painless disease. Added to this, modifying their oral hygiene regime can hit you with some resistance, especially as their parents taught them how to brush since early childhood!

• Have you been surprised by any aspect of the job?
The main surprise so far has been how much research really goes into the field of periodontology. It's amazing how many periodontal journals there are, as well as how many high quality scientific papers come through every month. There is research on absolutely everything: treatment techniques, grafting and regenerative materials, periodontal medicine, stem cell biology – the list goes on!

• What personal attributes do you feel are important in periodontology?
The specialty is a very friendly one, and you would certainly feel this if you were to join us at our British Society of Periodontology (BSP) conferences. I think that inherent attribute paves the way for you to become a successful periodontist, as the patient interaction is so key in achieving high quality treatment results, as well as helping to build your referral base with local dentists.

• What advice would you give to a student or trainee considering the specialty?
To know if you want to specialise in a certain field of dentistry you firstly need to experience it in some way. Consider visiting a local specialist in both primary and secondary care settings. If that inspires you then join the BSP and ask to join our new Early Career Group (ECG). We can provide more information about different career pathways in periodontology, as well as give you the opportunity to meet like-minded colleagues, specialty trainees, academics and recently qualified specialists. We meet at every BSP conference and also ensure we arrange a great informal dinner out too!

A FRESH LOOK AT CONSENT

A recent legal ruling has clarified the information that clinicians should share to ensure informed patient consent. MDDUS dental adviser **Claire Renton** looks at what this means for dentists

AS dentists, we are all aware of our professional duty to provide patients with enough information to allow them to make informed decisions about their dental treatment. It is a topic that generates many advice calls to MDDUS and plays a key role in many of the cases we deal with. There is also extensive advice and guidance available in this area from the likes of the General Dental Council and other organisations.

But a recent, high-profile legal judgement issued by the Supreme Court has clarified the way in which informed consent should be viewed, including the nature of the information that must be given to patients. It also confirms that the position in Scotland should be regarded as the same as the rest of the UK.

The case of *Montgomery v Lanarkshire Health Board* has crystallised the law in relation to consent and attracted more than a few headlines, not least because of the £5.25 million award. And while this particular case relates to medical care, its implications do extend to dentistry.

In essence, Mrs Montgomery experienced complications during the birth of her son. The baby's head failed to descend properly due to a shoulder dystocia – a rare complication where the baby's shoulder lodges behind the mother's pubic bone and essentially becomes stuck. In this unfortunate case, there was a 12-minute delay between the baby's head appearing and delivery, during which time the cord was completely or partially occluded. Sadly the baby suffered significant cerebral palsy.

Mrs Montgomery alleged negligence saying that before the birth she should have been warned about the possibility of shoulder dystocia, as she was only just over five feet tall and diabetic. She also claimed that abnormalities on the tracing of the baby's heart during delivery should have prompted a Caesarean section.

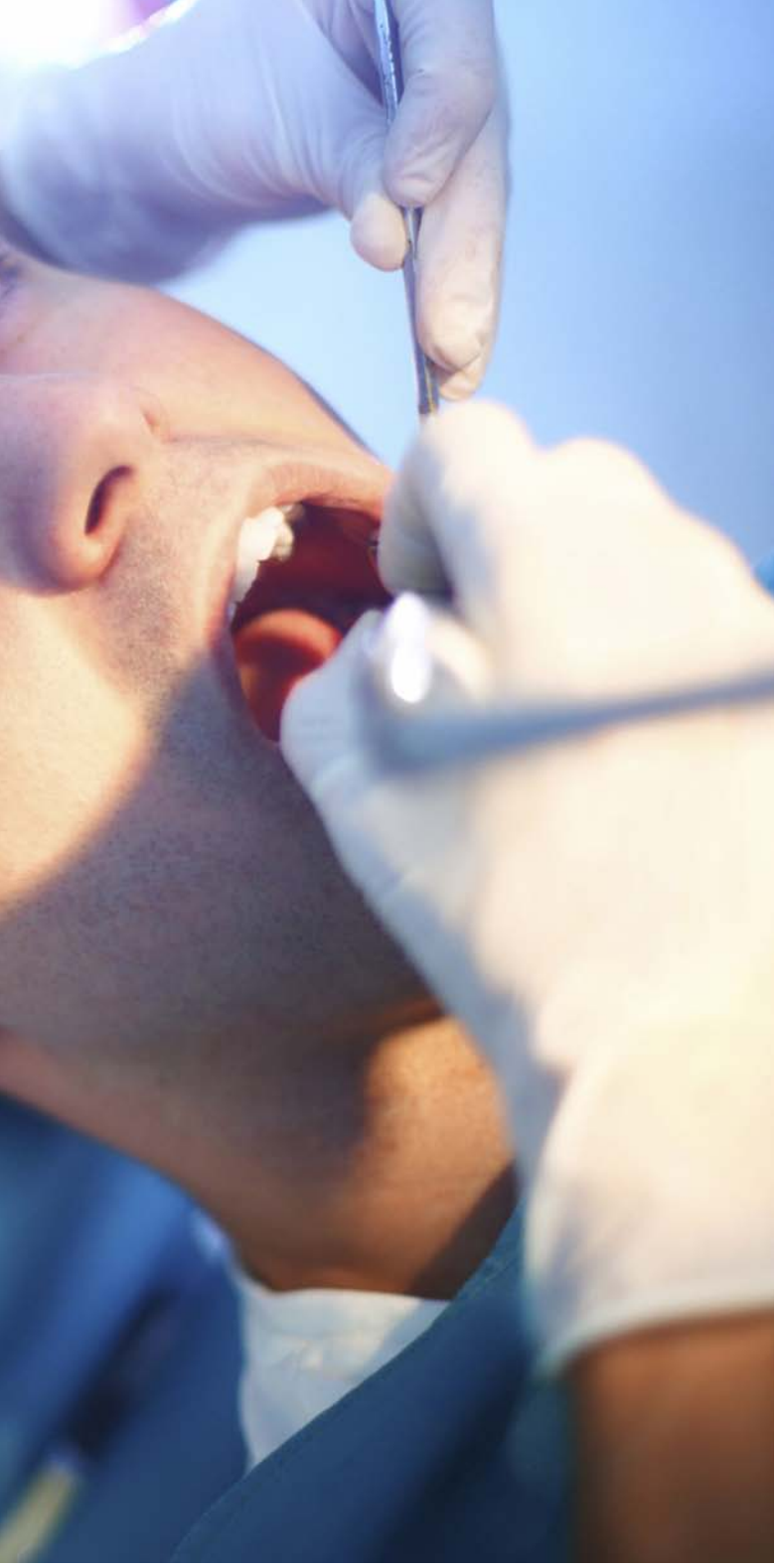
Initially Mrs Montgomery lost her case at trial and later on appeal, but she went to the Supreme Court and won.

Explaining dental risk

So what has all this got to do with dentistry? I agree it's unlikely that we will ever have to advise a patient on such a condition and I admit I had to consult with my favourite clinician, Dr Google, to find out exactly what a shoulder dystocia was. But there are significant lessons to be learned here and from now on, this case changes the type of information we are required to give to a dental patient during the consenting process.

In the past, we simply assessed how likely a complication was before deciding whether or not to inform the patient of this risk. For example, the risk of fracturing the mandible during the extraction of a mobile, periodontally-involved tooth in a young, healthy, six foot rugby player is so small that it's unlikely that we would inform him of this possibility before the extraction. In contrast, in cases where this complication is more likely to occur then we were obliged to inform the patient of the risk. For example, the chance of a fractured mandible is increased to the level where it would be necessary to issue a warning if the tooth is lone standing, firm and the patient is a tiny 80 year old with osteoporosis.

So our decisions on whether to inform the patient or not were based mainly on risk. If the complication was likely to occur, then we warned the patient. If the risk was low, we kept quiet. Yes, I know if the risk was small but the consequences were severe such as anaesthesia or paraesthesia following wisdom tooth removal then we are also obliged



to warn the patient, but apart from these exceptions, in the main, the decision to warn the patient or not was based on risk - the likelihood of it occurring in percentages.

The patient's view

The Montgomery case, whilst not changing the law significantly, does force clinicians to look at things rather differently. It sets out more clearly what our obligations are in terms of information disclosure. The focus now is on matters that the patient would find important, not just the clinician's assessment of the likely risk. Within the judgement it says: "...it follows...that the assessment of whether a risk is material cannot be reduced to percentages." It then makes it clear that the assessment of relevant information to disclose cannot be based solely on the percentage risk of occurrence, but must include an assessment of what the patient would find important. The judgement also then says that the courts will have the final say in "determining the nature and extent of a person's rights... not the medical professions" .

The judgement states: "An adult person of sound mind is entitled to decide which, if any, of the available forms of treatment to undergo, and

"The Montgomery case sets out very clearly what our obligations are in terms of information disclosure"

Nadine Montgomery successfully sued Lanarkshire Health Board over negligence on the birth of her son Sam, who was born with cerebral palsy

her consent must be obtained before treatment interfering with her bodily integrity is undertaken. The doctor (dentist) is therefore under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments. The test for materiality is whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it."

So, in practice, what does this mean? Well, in addition to warning a patient of likely complications and rare but severe complications, we are now also required to assess whether or not a particular patient would attach significance to rare complications and therefore should be warned about them before embarking on treatment. In other words, stand in their shoes and make a judgement on whether or not they would want to know about a rare but possible complication before agreeing to treatment.

Just to make it a tad more challenging, the patient does not have to ask specific questions about rare risks as it's been pointed out that a lay person should not be expected to know what questions to ask. Obviously the safe thing here is to fully explore any issue the patient raises and ensure the discussion is fully documented in the clinical records.

It is always good to reflect upon our interactions with patients and perhaps here is a chance to check that our consenting processes are fit for purpose and incorporate the new additional requirement.

If you ever have difficulty in assessing what you think a particular patient might be concerned about, even if they do not ask any questions about specific risks, then contact MDDUS for advice.

Claire Renton is a dental adviser at MDDUS

KEEPING SOLDIERS **BITING** FIT

Adam Campbell meets army dentist Orianne Moxon of the RADC

AN army marches on its stomach, Napoleon once said, but toothache, it could be argued, runs a close second to shortage of food when it comes to slowing down a soldier on the way to the battlefield. The old adage being: "an army that cannot bite, cannot fight".

The Army Dental Corp of the British Army was formed in 1921 after World War One with the recognition of the serious wastage of fit soldiers due to the lack of proper dental care – though some historians claim the pivotal moment was when General Douglas Haig was said to have developed a severe toothache around the time of the First Battle of Ypres. Finding that there was no dentist available in the British Army to offer treatment, a French dentist had to be summoned from Paris.

It was later granted the Royal prefix in 1946 and the Royal Army Dental Corp (RADC) today is responsible for the maintenance of dental health among personnel serving throughout the world.

Joining the RADC was an obvious choice for Orianne Moxon, now a major in the service. "When I was doing my A levels, an RADC careers officer came to do a talk for an assembly at my school. I had always had an underlying interest in the Armed Forces and was considering a Gap Year Commission but at that stage I already knew that I was going to apply for dental school. Finding out that I could be a full-time dentist in the Army was a no-brainer for me."

Instead of the Gap Year Commission, which would have seen her get some army training before going to university, Orianne decided to start her dental degree at Bristol University in 2003 first and then make her move. "I applied for a dental cadetship with the RADC when I was in my second year of dental school, and two weeks after my graduation I walked into the arms of the RADC, ready to prepare for the Royal Military Academy Sandhurst a few weeks after that."

Soldier in the chair

Orianne is now one of a 900-strong team employed under the tri-service (Army, Air Force, Navy) umbrella of the Defence Dental Services, which looks after around 200,000 military patients. Her current part in that huge effort is running a single-chair practice in Woodbridge in Suffolk where she is a senior dental officer with the 23 Parachute Engineer Regiment.

So is there a difference between treating soldiers and civilians? "The general dental health needs of the Armed Forces are not too different from the general UK population," says Orianne, going on to stress some advantages offered by a more protected environment.

"When talking to my civilian colleagues I do feel we are privileged to have a little more time to spend acclimatising nervous patients to treatment without having to worry about the personal financial implications. We do have primary and secondary healthcare referral systems in place, but I think if you can turn a nervous patient around in the primary care dental setting, in the long run you've saved a lot of time and money for all."

One of the issues Army dentists do have to deal with, she says, arises because soldiers on operations or exercise are not allowed to drink alcohol. Understandably, they have to seek little pleasures in other ways. "A hard part of the job is trying to administer oral health advice to patients who know full well the oral and general health risks of their sugar and tobacco intake, for instance, but are just not in a position to make any changes. Their cigarettes, sweets or high-energy drink may just be something that helps them get through the long hours, provides some morale and helps them cope with the stress of the day. That is hard to overcome, both as a patient and as their dentist."

Another issue has to do with the hierarchical nature of the services – enlisted men and women are used to taking orders from their superiors. "Gaining informed consent can be interesting too," she says. "A lot of patients with complicated treatment plans often tell you to 'Just do whatever you feel is best Ma'am – you're the boss'."

Even if the dental health needs of your military patient are not that different from those of the average patient on civvy street, the opportunities that arise for a dental officer are another matter altogether. What Orianne has enjoyed most about the job so far, she says, is "the opportunity for personal development – be that through sport, travel, adventurous training, going on exercise or working in and amongst some really interesting military units".

Hearts and minds

Travel has been central to that. From the very start of her training, Orianne has been on the move. After Sandhurst she went to Bulford in Wiltshire to complete her vocational training. She was then posted to Germany for just over three years. "It was a large multinational HQ and there were British, French, Americans, Germans, Dutch, Cypriots and Belgian Armed Forces working there – it was an awesome experience." Her three years in Germany came with the added bonus of a chance to work in Holland and Belgium, as well as doing some travelling around Europe.

But by far her most interesting and challenging post to date, she says, is the one she completed before starting her current job in Suffolk. "I ran a single chair dental centre on Thorney Island with 12, 16 and 47 Regt Royal Artillery Regiments, whilst also providing the dental care for 33 Field Hospital, who are based in Gosport."

"They use twigs [as toothbrushes], which although not ideal, is all they have"

33 Field Hospital's role is to deliver and provide deployed hospital care in any environment, and the unit has recently completed operations in both Iraq and Afghanistan. So far Orianne has not been deployed on a military operation, but the association with 33 Field Hospital did bring with it the opportunity to take part in Exercise ASKARI Serpent, a training exercise to east Africa which she describes as "the best experience I've had so far in the Army".

"I got to lead two dental teams on an exercise to Kenya. We spent four weeks on a hearts and minds medical exercise, visiting remote rural villages and setting up a mobile (tented) primary healthcare unit. We delivered much-needed free healthcare to hundreds of locals alongside a team of regular and reservist doctors, nurses, midwives, health visitors and other allied healthcare professionals, such as paramedics, pharmacists and combat medical technicians."

Going out on the exercise, Orianne had no idea what issues they were going to come up against. One of the first was language, a hurdle crossed with the help of the Kenyan Red Cross, who provided the team with translators. Another was the fact that many of the patients she came across had never actually used a toothbrush. "They do, however, use twigs which although not ideal is all they have."

It was a very different experience to working in the UK but she relished the challenge. "I treated over 200 patients in the space of eight working days, and extracted more teeth than I care to remember. But I will never forget a young warrior called 'Military', aged between 13 and 16, who walked over two hours in the blistering heat, through the bush on his own, to come and see us – we saw elephants walking free across the very same roads he had walked not 24 hours later!"

OPPOSITE: Major Orianne Moxon (left) with dental nurse Lance Corporal Anna Cole on exercise in Kenya. TOP: Orianne treats Kenyan patients in a field dental surgery set up inside a tent. ABOVE: People travel considerable distances and form long queues to receive dental treatment.

Go for it

By Orianne's own admission she had always thought the Army might be the place for her, and her seven years so far have been packed with interesting experiences both inside and outside dentistry. She has no regrets about her decision to "walk into the arms of the RADC" and passionately encourages trainee dentists thinking about a similar career not to hesitate.

"Go for it!" is her advice. "There are opportunities with both the regulars and the reserves, but do your research as to what suits you. The career options aren't just for new dentists either – qualified dentists, including dentists with specialist interests and beyond, can apply to join the RADC too.

"Oh, and make sure you can run a mile and a half in under 10.5 minutes, and get practising the sit-ups and press-ups!"

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

TREATMENT

SUPERVISED NEGLECT

DAY ONE
A 53-year-old man – Mr T – attends his dental surgery for an emergency appointment with swelling in his upper jaw and two loose teeth. The dentist he had been consulting on numerous occasions for the last eight years – Mr L – has moved on to another practice so he instead sees Mr G, the senior partner. Mr G examines the patient and takes a series of radiographs. These reveal that Mr T has suffered considerable periodontal bone loss associated with 14 teeth. He discusses his findings with the patient, who asks why Mr L had not drawn attention to the problem. Mr G can offer no explanation.

DAY 24
Mr T re-attends the surgery with significant pain in LR7 and LR8 which are both significantly mobile. Mr G judges that both teeth are no longer viable and the patient opts for extraction. The dentist advises that his gum disease is now so advanced it may not be possible to save some – or most – of the affected teeth.

MONTH 6
Solicitors representing Mr T write to the practice alleging clinical negligence over the patient's treatment by Mr L. The letter also includes a request for copies of the patient notes accompanied by a signed consent form from the patient. Mr G forwards the letter to Mr L at his new place of employment and advises him to contact the solicitors directly. Mr L phones MDDUS and a dental adviser asks him to forward copies of the letter and Mr T's full dental records. A report is commissioned by a dental expert who examines the case papers.

THE expert considers the patient's treatment over the eight-year period under Mr L's care. Bitewing radiographs taken on Mr T's first consultation with Mr L show most of the molar teeth have been filled and three had been root treated. There were a number of existing caries needing treatment but periodontal bone levels of the molar teeth were satisfactory at the time. No evidence of the state of anterior teeth at that time is recorded.

In subsequent years Mr T attended for numerous examinations and treatment including fillings and regular scaling and polishing. A radiograph taken three years ago shows periodontal bone loss associated with UR6 and UR7 but there is nothing in the records to show any action was taken based on that information.

Examination of the patient by the expert reveals periodontal pocket depths of greater than 5mm in 12 teeth with seven teeth at mobility grade I or II. Based on this examination and available radiographs, the expert offers a poor prognosis for several of Mr T's teeth with extraction necessary within 10 years. He believes that immediate extraction of some teeth would facilitate a more effective restoration plan.

The expert recommends a remedial treatment plan involving a periodontal specialist to remove any sub-gingival deposits from the root surfaces and then a number of extractions followed by implant retained crowns and bridges – providing there is adequate alveolar bone available for the placement of fixtures. A cost estimate is also provided.

The MDDUS adviser consults with legal colleagues over the case notes and the expert report. The lack of any reference to periodontal assessment of the patient over the period of his treatment by Mr L is considered legally indefensible. In consultation with the member it is decided that the case is best settled out of court with the amount based on estimated treatment costs for restoration as set out in the expert report.

Key points

- Avoid the charge of "supervised neglect" by using every appointment as an opportunity to assess the overall oral health.
- Ensure that patients understand clearly the significance of periodontal disease and provide advice on good oral hygiene.
- Keep adequate notes of home care advice given to patients and the importance of flossing, brushing and smoking cessation to avoid gum disease.

OUT THERE

PLAGUE PULP Remnants of the genetic makeup of plague bacteria have been found recently in the teeth of victims of the Black Death and the major plague epidemics at the end of the Iron Age, the *BDJ* reports. In many victims, plague bacteria entered the bloodstream and thus the dental pulp. Oslo researchers are analysing the plagues' genetic codes and the influence of factors like climate change and rat infestations in the hope of predicting future outbreaks.

PRESIDENTIAL PERIO US president George Washington famously suffered poor dental health throughout adulthood, consulting a range of top 18th century dentists. During his inauguration he had only one real tooth in his head and relied on dentures made from a combination of hippo teeth, ivory, horse teeth, human teeth, gold and lead. Source: mountvernon.org

DENTIST OR DIVORCE? Dentists may not expect to top the list of favourite experiences, but a recent survey suggests one in seven patients would rather endure a divorce, move house or have a job interview than spend half an hour in the treatment chair. The Dental Health Organisation found 12 per cent of patients suffer from extreme dental anxiety. Men are most commonly put off by pain or the thought of being scolded for poor teeth (23 per cent) while for women it's drill noise that causes most anxiety (35 per cent).

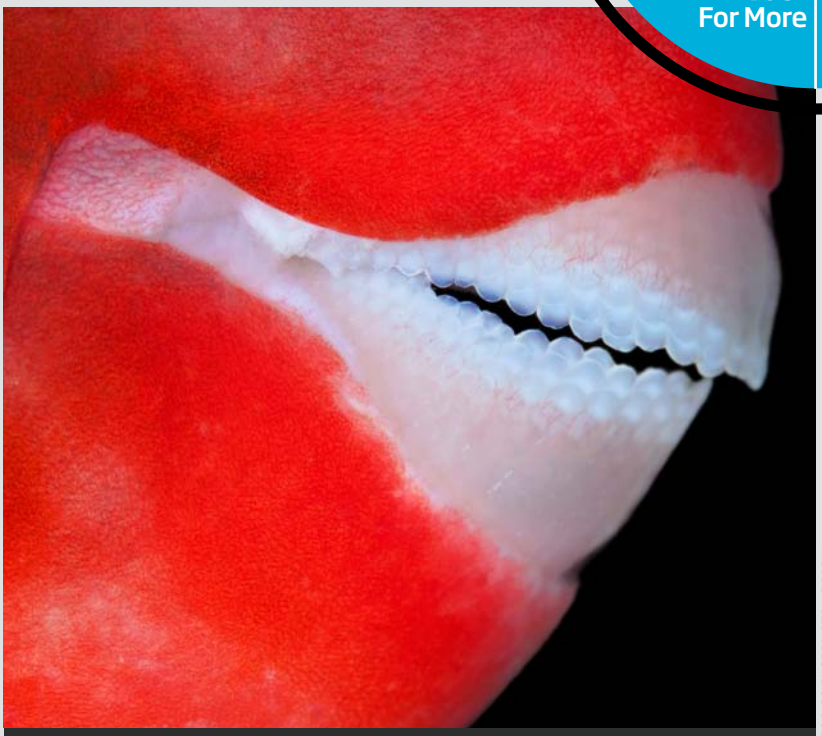


PHOTO: SCUBAZOO/SCIENCE PHOTO LIBRARY

NAME THAT BITE

Stumped? The answer is at the bottom of the page

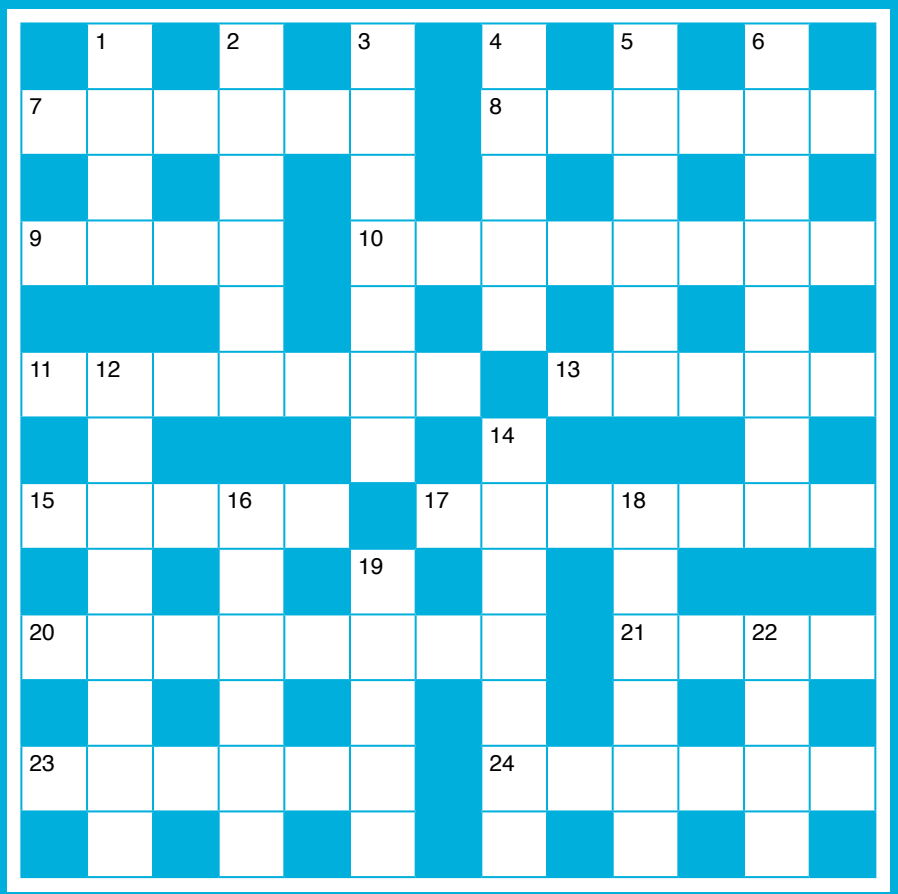
CROSSWORD

ACROSS

7. Photographic device (6)
8. Pertaining to lips (6)
9. Hackney carriage (4)
10. Technique to promote tooth bonding (4,4)
11. As spoken in 13? (7)
13. Mediterranean country (5)
15. Centres (5)
17. Collection of pus in tooth and tissue (7)
20. Gums covering tooth-bearing border (8)
21. Promise (4)
23. Deliverer of food (6)
24. Thin layer of porcelain (6)

DOWN

1. Figures (4)
2. Towards the anterior midline (6)
3. Side of tooth adjacent to palate (7)
4. Assertion (5)
5. Thing (6)
6. Hardened plaque (8)
12. From the equatorial region (8)
14. Notice (7)
16. Half a quarter (6)
18. Dental restorations (6)
19. All (5)
22. You (archaic) (4)



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

NAME THAT BITE? *Mouth of parrotfish*

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