Sound Bite

ISSUE 12

FEELING THE PRESSURE

HOW TO BEAT WORK-RELATED STRESS

ALSO INSIDE

AN MDDUS PUBLICATION

MDDUS

Welcome to your SoundBite

DENTISTRY can be a fantastic, rewarding career but research suggests levels of work-related stress are high. Running behind schedule, coping with uncooperative patients, and long working hours are just some commonly reported stress factors. My article on page 4 explores this issue in more detail and looks at some potential solutions.

Complaints from patients are often cited as a source of stress, but dentist-turned-business coach Alun Rees argues that they should be welcomed. Find out how to make the most of negative feedback on page 6.

You might think data protection laws are something only practice principals or managers have to worry about, but they apply to new dentists too. MDDUS senior information governance officer Alex Lyons offers a useful overview of what you need to know on page 7.

Making the move from VT to associate can be a daunting step with lots of things to consider. On page 10 MDDUS adviser Claire Renton highlights some of the most important areas, including GDC registration, indemnity and CPD. If you're looking for more career challenges, our article on page 8 considers what it's like to work as a prosthodontist.

Modern dentistry owes much to the efforts of one pioneering man born 200 years ago this year – Sir John Tomes. On page 12 Allan Gaw looks at how this determined clinician drove out back-street charlatans and crafted a respected and skilled profession. And our case study on page 14 details a problematic extraction involving a retained root.

• **Sameera Teli**
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MDDUS

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DUTY OF CANDOUR GUIDANCE FOR DENTISTS

DENTISTS must be open and honest with patients when things go wrong and apologise as soon as possible, according to new draft guidance from the General Dental Council.

The regulator has launched a consultation seeking views on its new duty of candour guidelines. It follows Sir Robert Francis' report into the failings at Mid Staffordshire NHS Foundation Trust which emphasised the importance of openness and transparency in healthcare.

The GDC was one of eight organisations to sign a joint statement in October 2014 called *The professional duty of candour*, but this new draft document offers more detailed guidance.

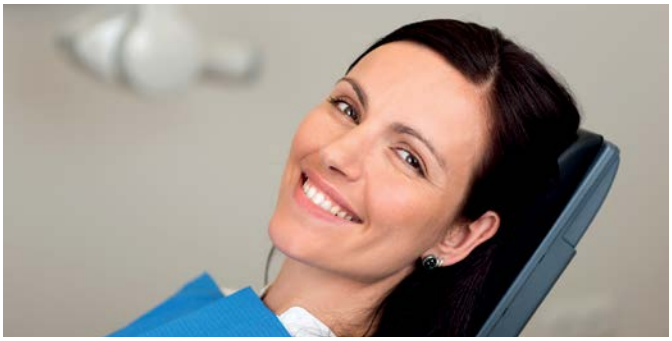
It underlines the importance of a thorough discussion with patients before beginning treatment, ensuring they have enough information to make their decision.

If something does go wrong, dentists will be expected to tell the patient; apologise; offer an appropriate remedy or support to put matters right (if possible); and explain fully the short and long term effects of what has happened.

A personalised apology should also be offered "as soon as possible" after a patient suffers harm or distress, the guidance states, adding: "Apologising to the patient is not the same as admitting legal liability for what happened. You should not withhold an apology because you think that it might cause problems later."

Under the new guidance, dental managers and employers will have to encourage a culture of openness and honesty amongst staff, ensuring procedures are in place for staff to raise concerns.

The GDC is asking healthcare professionals and the public "whether it's got the draft guidance right". The consultation runs until December 18, with more information available on the GDC website.



HIGH DENTAL SATISFACTION, NHS TEST SHOWS

DENTAL practices received 97 per cent positive ratings from patients, according to their first batch of Friends and Family Test (FFT) results.

The official NHS survey was rolled out to dentists in April.

Data just published from the first three months shows the overwhelming majority of patients who responded said they would recommend their dental service to a friend or family member. Only one per cent of respondents said they would not recommend it.

The figures come as the FFT marks its 10 millionth piece of patient feedback.

It was launched in April 2013 and has since been fully rolled out across the NHS. The test aims to gauge patient views on service quality, allowing providers to react quickly to any reported problems.

In the first month for dental practices, feedback was submitted by almost 191,000 patients. In May there were 151,000 submissions and almost 143,500 in June. Data was returned by just over 6,000 practices in April, falling to just over 5,300 in June.

Commenting on the survey results, an NHS England spokesman, said: "Given the overwhelmingly positive scores that have been recorded, it is a huge vote of confidence and appreciation for the hardworking staff of the NHS across England."

DENTISTS HAVE ROLE TO PLAY IN DETECTING DEMENTIA

DENTISTS may have an important role to play in helping to detect the early signs of dementia in patients, according to the British Dental Health Foundation.

People with dementia are often unable to adequately maintain their oral health and this could be a key signal for early intervention. The BDHF believes that offering people with dementia proper care plans could ensure both their oral and overall health is not put at further risk.

Currently there are more than 850,000 people with dementia in the UK, according to estimates by The Alzheimer's Society, and this number is expected to rise to over one million by 2025. Studies have shown that people with dementia have poorer oral health than those without the disease due to impairment of cognitive skills and a reliance on care providers.

Chief Executive of the British Dental Health Foundation, Dr Nigel Carter OBE, said: "Dementia patients in early stages of the disease may have trouble communicating the problems they are having with their oral health.

"These patients need to rely on their dental professionals to recognise behaviour which is out of the ordinary and which may indicate mental health problems in order to get quick and effective support.

"As dementia is progressive, recognising it early means that an effective care plan can be put into place before it leads to further health problems, including painful and extensive dental health issues."

CONSULTATION ON LANGUAGE CHECKS FOR DENTISTS

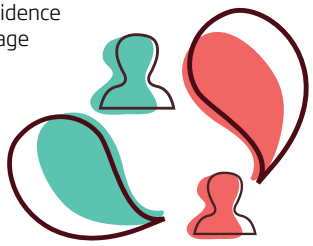
A CONSULTATION has been launched on a draft policy to introduce English language checks for dentists who want to work in the UK.

The government unveiled plans late last year to extend language testing to include clinicians from EU countries. Previous laws only allowed checks on those from outside the European Economic Area (EEA).

The new powers mean the General Dental Council can now ask for evidence of a dental professional's language skills prior to registration. It can do this if there are concerns that they don't have sufficient knowledge of English.

Would-be registrants who are unable to provide evidence of their abilities will be asked to take an English language test.

The GDC has launched a consultation to gather views on the type of information that will be accepted as evidence of language skills; the use of the International English Language Testing System (IELTS) exam to assess applicants; and whether the draft guidance should be applied to all applicants, including those who have trained and qualified from within the European Economic Area and those who have trained from outside the EEA (non-EEA).



It is thought the new powers will come into effect in March 2016. They must be enforced "proportionately" and so will apply to all dental professionals wishing to register or restore their registration with the GDC. This includes dentists seeking to re-register when they have failed to pay their annual retention fee.

EU law forbids a "blanket" approach to assessing English knowledge so the GDC would be unable, for example, to require English tests from all EEA applicants.

The government's consultation document published last year offered reassurance to UK clinicians, stating: "For graduates of UK universities, the fact that the registrar will be able to rely on the information supplied by applicants with their registration application should mean that a registrar should be able to be satisfied about the English language ability of UK qualified applicants with no additional procedural burden."

The consultation is open until January 4, 2016 on the GDC website.

NEW ORAL CANCER TOOLKIT

AN online toolkit designed to help dentists and GPs spot the signs of oral cancer has been launched by Cancer Research UK.

The resource details how to identify and respond to possible cases of the disease, and also highlights risk factors. It includes a detailed image library, a referral guide, case studies, examination videos and a CPD quiz.

The launch coincides with new statistics from Cancer Research UK that show oral cancer is now the tenth most common cancer in men and fifteenth most common in women.

Nearly all cases of oral cancer in the UK (90 per cent) are linked to lifestyle and other risk factors with the highest risks from smoking. Drinking alcohol, the human papilloma virus (HPV), and poor diet have also been linked to oral cancer.

The toolkit, supported by the British Dental Association and approved by the Royal College of GPs, can be accessed at **tinyurl.com/nax6b9u**

UNDER PRESSURE

High levels of stress continue to cause problems in the dental profession – but what can be done about it? *SoundBite* editor and dentist **Sameera Teli** investigates

THE working life of a dentist is a physically and mentally demanding one and evidence suggests levels of occupational stress are high. With the risk of suicide amongst dental practitioners now greater than in the general population, understanding and finding ways to tackle work-related stress are crucial.

The Health and Safety Executive defines work-related stress as: "The adverse reaction people have to excessive pressures or other types of demand placed on them at work."

This highlights an important distinction between stress and pressure: pressure can provide positive motivation enabling us to perform better, whereas stress is a response to excessive and prolonged pressure.

Short-term stressful experiences such as the compressor breaking down in the middle of a busy working day, or a sudden staff shortage, may feel like a major irritation at the time but they are unlikely to have a long-standing impact. It is the persistent, lower levels of stress that build up over time that can have more serious physical, emotional and behavioural effects.

Health impact

Myers and Myers published a study in the *British Dental Journal* in 2004 called *"It's difficult being a dentist": stress and health in the general dental practitioner*. They questioned more than 2,400 dentists across the UK and found that perceived stress was significantly correlated with measures of dental stress.

"Running behind schedule" and "coping with difficult uncooperative patients" were the most common work-related stress factors, alongside staff and technical problems, job dissatisfaction and long working hours.

When asked about their health and wellbeing, 60 per cent of dentists reported feeling tense, depressed and had difficulty sleeping. Minor psychiatric symptoms and cases of backache were also high. Researchers also noted a link between occupational stress and both alcohol consumption and lack of exercise, with more than a third of dentists admitting to being overweight.

In 2014 the British Dental Association conducted the *Dentists' Wellbeing and Working Conditions* surveys which found that almost half of GDPs (47 per cent) reported low levels of life satisfaction, while six out of 10 said they had felt anxious the previous day. Compared to the UK population, wellbeing among dentists was lower, and had dropped significantly from the previous year. There was a strong association between personal wellbeing and work-related stress, with those doing mostly NHS dentistry reporting a lower state of wellbeing than those doing mainly private work.

Stress-related illnesses are a common cause of early retirement amongst dentists. Income protection company Dentist Provident reported last year that the majority of claims they received for time off work were due to psychiatric and musculoskeletal disorders, with high pay-outs for conditions such as depression and anxiety disorders.

Stress is also an issue for our medical colleagues. In a bid to address this, a dedicated occupational health service for GPs in England will be launched in April 2016. Announcing the programme, NHS England chief executive Simon Stevens cited burnout and stress as some of the reasons why GPs are leaving the profession. In addition to the occupational health scheme, all NHS staff will be given access to physiotherapy, mental health therapies, and smoking cessation as well as fitness classes such as Zumba and yoga.

It will be interesting to see the uptake and outcome of such an initiative, and perhaps this is something that could be introduced to the dental profession.

Minimising stress

In the meantime, there are a number of areas dentists can look at to reduce stress. First and foremost, dentists who are feeling stressed should not ignore the warning signs and should take swift action.

Keep moving

Busy dentists may feel they do not have the time or energy to exercise, but in such a sedentary career, even simple adaptations can help. This could be as basic as walking to the waiting room to collect and receive patients, going for a walk at lunchtime, or walking to and from the work place.

Making connections

Dentistry can be viewed as a rather solitary profession, a factor that does nothing to alleviate stress levels. The clinical working environment is usually relatively small, with an even tighter focus on the patient. Busy dentists often find themselves sitting still for extended periods, with little opportunity to interact with colleagues, even in larger practices. Having worked in a one-surgery practice, I am only too aware of the isolation that can be experienced as a dentist.

Seeking out opportunities to regularly speak with other dental practitioners, such as through peer review or social gatherings, can reduce stress factors and help you maintain an important perspective on day-to-day issues.

Positive moves

It is important to remember that we are in control of where we choose to work. Think about what key factors allow you to feel valued and increase satisfaction in your working environment. If any factors are missing, what could reasonably be done to alter this? Would you consider changing to a job which better meets your needs? Such changes may have perceived negative factors such as increased travelling or lower pay, but long term you may be happier in the workplace.

Patient autonomy

As dentists we are constantly identifying and diagnosing multiple diseases in our patients, and we will each have our own views on how these should be managed. We must remember that patients have their own perspective and beliefs which will impact on the decisions they make about their treatment and general oral healthcare. We may not always agree with them but it is important that we allow patients to retain ownership of their problems and that we do not take them on as our own.

Time management

Effective time management can significantly reduce stress in the workplace. Team work is key, so form a good relationship with the reception staff who organise the appointment book, and with your dental nurse.

The more research there is into the causes of job dissatisfaction and occupational stress, the more we can learn to implement the most effective ways of tackling it, both at an individual and organisational level. National schemes such as Investors in People, as well as training and advice provided by the likes of the MDDUS Risk Management team, have helped many dental practices develop effective management systems which address potential stress points in practice and work to reduce stress occurring in the workplace.

As dental practitioners, we will inevitably be exposed to stress throughout our working lives. We are all affected by stress differently so it is important that we are able to manage it effectively and aim for fulfilling, valuable and successful professional careers.

Sameera Teli is a dentist and editor of SoundBite

COMPLAINTS WELCOME

Instead of fearing it, negative feedback should be welcomed, argues dentist-turned-business coach **Alun Rees**

"MISTAKES are going to happen. Acknowledge them. Rectify them. Learn from them. Move on." These words spoken by US President Josiah Bartlett in *The West Wing* can equally be applied to complaints.

There is nothing like a real or alleged error to stimulate the flow of adrenaline, initiating the fight-or-flight response. In real-life dentistry both reactions are the wrong way to deal with a mistake. A fight, confrontation or denial, although instinctive, only leads into deeper waters. Similarly, once a mistake has been made, to try to flee from the fact and its consequences only compounds the error. Early in our careers there is a temptation to ignore things and hope they will go away. You might get away with it once or even twice but ultimately the problem will return to bite you.

It used to be the case that some of these patients would vote with their feet, sharing their complaints with a handful of friends and family to undo your carefully made reputation. Now this effect is magnified greatly as social media and the power of the internet give even the silent ones a voice.

So we need to flip our approach to complaints. Instead of being feared and avoided, negative feedback should be sought out and valued. It's a scary thought isn't it? Yet if we are to grow as professionals we need to ensure that we listen and communicate with great care and skill.

But first how can we minimise negative experiences? A drop of prevention is better than a bucketful of cure.

Before any treatment, make sure expectations are realistic, both yours and the patient's. Do they truly understand what is involved? Do you run the risk of over-promising something that is then under-delivered in the patient's eyes? Remember, words of caution said before treatment are a warning, but the same words said afterwards are an excuse.

Are you sure that you have the skills you need? Can you get some advice from a colleague on what might go wrong during the planned treatment?

If something doesn't go to plan then take the opportunity to share it with a senior colleague, sooner rather than later; don't plough on hoping that it might work out for the best.

During the treatment did you keep the patient informed of the process? Did you tell them what was going to be happening next? If something happens that might increase treatment time, explain what, why and how long. Make sure you tell them what to expect over the next few days, and let them know if you've made changes to the treatment plan.

After treatment, did you follow-up on anything where the patient might be expected to have pain or swelling? The telephone is still one of our greatest tools and a brief, sympathetic call can work wonders.

Do you know the practice protocols for dealing appropriately with any negative feedback? Don't let a telephone call that could prove to be a great learning experience for all escalate into a full-blown complaint. People want someone to listen to them. If necessary, return the call. Make sure that you understand fully what the concerns are and tell the patient what you will do to put things right and then do it.

Always say sorry, even if you are absolutely sure that your treatment, advice or procedure has been as good as it could be. Start any conversation with the words: "I am sorry to hear that" – and mean it.

Your efforts may prove unsuccessful and the patient may want to make a formal complaint. Ensure that you follow current guidelines and the patient understands how to go about voicing their concerns. Be on the patient's side. Avoid anything that could be interpreted as adversarial. Keep your trainer informed at all times.

Deal with things quickly; if possible arrange to meet the patient face-to-face. Don't drag your heels in the hope that it will go away, or take a complaint personally.

When you do meet the patient, keep your composure, know the complaint procedures, take notes, be sympathetic and apologise for the fact that the patient has had to complain. Tell the patient the time frame in which they can expect action and stick to it.

Investigate and keep the patient informed at every stage of the process. Communicate what you have learned. This might include an admission that things were not quite as they should have been, followed by an explanation of the actions that have been taken to avoid any repetition of the error or perceived slip in service standards. Be honest and transparent.

If the complaint cannot be dealt with satisfactorily in-house or the patient is requesting compensation then contact MDDUS immediately. They are the experts and will be used to handling on a daily basis the problems that happen for you once in a blue moon.

Alun K Rees BDS is The Dental Business Coach. An experienced dental practice owner who changed career, he now works as a coach, consultant, troubleshooter, analyst, speaker, writer and broadcaster. www.dentalbusinesscoach.co.uk

SAFE AND SECURE

Are you up-to-date with the requirements of the Data Protection Act? MDDUS information governance officer **Alex Lyons** looks at what dental trainees need to know

YOU are just starting out on your new career and everyone is full of advice. There is much to remember and it can be difficult to prioritise. While it may not be top of your list, the Data Protection Act 1998 (DPA) is one piece of legislation that will impact you on a daily basis.

Privacy and data protection is an area where people often feel they aren't given enough practical help. The body set up to advise individuals and organisations on these issues is the Information Commissioner's Office (ICO), which interprets and enforces the DPA.

They ensure that anyone who "processes personal data" (patient information) complies with the Act's eight principles. There is a further definition of "sensitive data" which includes medical information for which there are more stringent obligations to be met. Those responsible for deciding how to process this information are known as "data controllers" and they must inform the ICO of this fact. There are few criminal sanctions that can be imposed under the DPA but failing to notify the ICO that you are processing personal data is one of them. Not a great way to start your career.

As a new dentist, you may think data protection is something only the practice principal or manager needs to worry about. But, generally speaking, the ICO do require associates to register as they are usually self-employed, trading as a separate legal entity from their principal dentist and are responsible for their own patient records. However, there are some exceptions to this rule thanks to the many arrangements that exist between principals and associates. Ask yourself the following questions:

1. Are you responsible for the control and security of patient records, and do you have other responsibilities associated with the data?
2. Do you have a patient list separate from the practice in which you treat patients that would follow you if you left?
3. Do you treat the same patient at different practices?
4. If a complaint was made by a patient, or data was lost, would you be legally responsible for dealing with the matter?

If you answer 'yes' to any of the above questions, you are likely to be a data controller and will need to register with the ICO. The annual fee is £35 for most organisations, including small and medium-sized businesses. It is unlikely you will have to pay the higher fee of £500 as this only applies to organisations with both 250 or more staff and a turnover of at least £25.9 million.

The DPA gives individuals (so-called "data subjects") the right to know what information is held about them. It provides a framework to ensure that personal information is handled properly. The Act works in two ways.

Firstly, it states that anyone who processes personal information must comply with the eight principles which require that data is:

1. Fairly and lawfully processed.
2. Obtained for specified and lawful purposes.
3. Adequate, relevant and not excessive.
4. Accurate and up-to-date.
5. Not kept for longer than is necessary.
6. Processed in accordance with the rights of the data subjects.
7. Kept secure.
8. Not transferred outside the European Economic Area without adequate protection.

The second area covered by the Act provides individuals with important rights, including the right to find out what personal information is held on a computer and most paper records. This is called a "subject access request" which, for dentists, will most commonly come in the form of requests for patient dental records.

There are strict rules and guidance on when/how to provide this information. Where an individual believes they are wrongly being denied access to any personal information, or feel their information has not been handled in accordance with the Act, they can complain to the ICO. The ICO will normally deal with such matters informally, but if this is not possible, enforcement action can be taken.

Individuals also have the right to object to their information being used to target them with unwanted marketing, which means dentists must be careful how they use confidential patient data. For example, deciding to send a mailshot out to all your patients simply to advertise a new product or promotion may be viewed as a breach of the DPA.

When examining the application of the Data Protection Act you should bear in mind the following points:

- It is a criminal offence to process personal data without being registered.
- Only registered data users/staff may access the data.
- Data must not be disclosed to third parties without prior patient consent.
- Retention of patient records must be managed in accordance with the Act.
- Data should only be kept for as long as is necessary for its intended purpose.

All dental practices should have policies in place covering data protection and data entries should be logged, with each staff member allocated a password. Computer systems should have audit facilities and measures in place to prevent data being accidentally deleted or tampered with. Adequate back-up records must be maintained and kept securely.

More detailed information is available on the ICO website at **www.ico.org.uk**, or you can discuss issues with an MDDUS adviser.

Alex Lyons is senior information governance officer at MDDUS

REBUILDING **SMILES**

The exciting field of prosthodontics offers a challenging combination of advanced diagnostic and technical skills

WHEN the topic of prosthodontics is mentioned, first thoughts often focus largely on the humble denture. But this varied and challenging specialty offers much more.

Broadly speaking, it is about the restoration and replacement of teeth using fixed, removable, implant or maxillofacial prosthodontics. That includes crowns, veneers, bridges, dentures and implants.

As well as mastering complex technical procedures, prosthodontists have advanced diagnostic and analytical capabilities that allow them to identify and treat a variety of dental problems before restoration begins. Specialists also treat facial abnormalities caused by injuries, birth defects and diseases. Add to this the scope for scientific research and education and the potential career paths widen further.

Entry and training

Dentists interested in becoming a specialist prosthodontist (and being included on the General Dental Council's specialist list) will first have to complete at least two years basic postgraduate dental foundation training. This should ideally include vocational training and experience of working in a wide variety of dental sectors. Although not essential, it is desirable for trainees to gain faculty membership such as the Joint Dental Faculties at the Royal College of Surgeons of England, the Faculty of Dental Surgery RCS Edinburgh and Royal College of Physicians and Surgeons of Glasgow, or the Faculty of Dentistry RCS Ireland.

Specialty training for prosthodontics usually lasts three years (4,500 hours) full-time, but many choose to train part-time over a longer period, allowing them to continue working part-time to help manage costs. Training is generally composed of 60 per cent clinical, 25 per cent academic and 15 per cent research, but this is flexible and can be adapted depending on the trainee's abilities and competency.

There are various routes to learning which are set out in more detail in the *Curriculum for training in prosthodontics* (published June 2010). Trainees are expected to demonstrate minimum competences in key areas and can undertake learning in a range of ways, such as validated self-directed and independent study; guided theoretical learning (possibly as part of a Master's degree in prosthodontics); technical skills development via simulation laboratory exercises that feed into a presentation portfolio; supervised clinical practice; work-place based training; or involvement in a research project.

The job

Prosthodontics forms part of the broader field of restorative dentistry which is described by the Royal College of Surgeons of England as aiming to "restore function and ensure an aesthetic, healthy and pain-free dentition." This encompasses a wide skill spectrum, from placing small crowns and treating snoring or sleep disorders, to managing patients with more complex treatment needs. Specialists may find themselves

assisting patients affected by loss of bone and/or soft tissues, those who have suffered facial trauma, or those with congenital oral defects.

Many dentists who successfully complete specialist prosthodontic training will work as private practitioners in specialist practice within a primary care environment. Those who achieve their three-year certification of completion of specialty training (CCST) may seek to work as a consultant in prosthodontics but this may require further experience and training.

Once qualified, one way to keep professional skills and knowledge up-to-date is by joining The British Society of Prosthodontics (BSSPD). It was founded 60 years ago and has a worldwide membership of around 500 clinicians. Membership offers reduced rates for conference attendance, a free subscription to the *European Journal of Prosthodontics and Restorative Dentistry* as well as access to research prizes, bursaries and learning materials.

Sources

- Curriculum for training in prosthodontics
- Career pathway information for restorative dentistry – Royal College of Surgeons of England – **tinyurl.com/oyjrtra**
- The British Society of Prosthodontics – **www.bsspd.org**

Q&A

Dr Phil Smith, senior clinical lecturer and honorary consultant in restorative dentistry

• What attracted you to a career in prosthodontics?
After qualifying I realised that what I enjoyed most was being able to restore and replace missing teeth to improve patients' lives. Throughout my years as a dentist I have been very fortunate to have worked with patients and colleagues who have kept me sufficiently motivated to rehabilitate people who require help to restore oral function and appearance. I came into dentistry wanting to make a positive difference to people's lives and prosthodontics has allowed me to do this.

• What do you enjoy most about the job?
It's a great challenge to restore and rehabilitate patients who are having difficulties with eating, chewing and their dental appearance. Over time, although there have been tremendous advances in technology and treatment possibilities, the underlying principles of prosthodontics have remained the same, it's just that nowadays we are able to reach our objectives in different ways. The most enjoyable part of the job is meeting such a range of individuals and being able to help them. Particularly rewarding for me is being involved in the treatment of cleft lip and palate. I can make a real difference to this group of patients.

• What do you find most challenging?
Being unable to meet patient expectations. Despite the great advances in technology and clinical techniques, we have to work within realistically achievable parameters, and on occasion these can fall short of what patients would like us to achieve. It is also frustrating not being able to provide more complex prosthodontic treatment for some patients. This may be because of their inability to cooperate sufficiently or as a result of other limitations, for example, systemic disease.

• Have you been surprised by any aspect of the job?
I am always surprised by the adaptability, flexibility and ingenuity of human nature and prosthodontics allows you to experience this at first hand. These qualities apply to colleagues and patients I have encountered. When these coincide for the common good some amazing results, beyond what could have been predicted, are achievable.

• What personal attributes do you think are important in prosthodontics?
Top of my list would be patience, closely followed by perseverance, and team working. Prosthodontics is a team game where science and art come together, although at an individual level much depends on practical skill and clinical/technical ability. It helps to lean towards being obsessive about what might be considered as fine technical details!

• What advice would you give to a trainee considering prosthodontics?
It is important to make sure you have a sound base in general dentistry and that you get plenty of practise to develop your clinical skills. Make sure that you enjoy the practical aspects of dentistry and be flexible in your approach to patient management. Becoming involved with the BSSPD (British Society of Prosthodontics) would be a good idea as this long-established specialist society is relevant to anyone with an interest in prosthodontics. It has an annual meeting with keynote speakers in the field. It also makes awards and it has resources that are useful in supporting trainees. Finally, I would encourage all new dentists to be prepared to embrace change and to learn new skills throughout your practising career.

MOVING

Making the move from VT to dental associate can be daunting. MDDUS dental adviser **Claire Renton** highlights the key areas to consider

IT'S LIKELY that by now you are fairly settled in your new job. You've worked out that most of the nurses are skilled, knowledgeable and keen to help, that the receptionist is the best person ever at multitasking and the principal is best avoided first thing on a Monday morning.

You have probably even had a stab at understanding the Statement of Dental Remuneration and have become familiar with some of the more usual claim codes. I bet that even the dentistry has got a bit easier, hasn't it? You are probably putting all your matrix bands on the right way round now and your IDBs are working first time... Ok, well at least second time. Pat yourself on the back! It's going so well!

Now I'm not going to burst your bubble with horror stories of what happens when things go wrong, I'm not even going to have a go about record keeping or behaving yourself at the Christmas party. I'm going to talk about the things you might want to consider getting into place over the next few months when it's time to move on.

What kind of practice do you want to be working in? Which aspects of dentistry interest and excite you? What type of people do you enjoy working with? These are decisions that you should be thinking about soon. There's a massive difference between facial aesthetic practices and smile designs and treating patients who struggle to fund simple fillings, but both types of practice bring professional rewards and are equally worthwhile.

"The advantages of having indemnity rather than insurance cover are massive"

What things do you need to get in place?

GDC registration

Well, you need to make sure you remain on the General Dental Council register. The annual retention fee is payable in December. If it's not paid and your name isn't on the register come January 1, you won't be allowed to practise and it can be really difficult to get back on the register without jumping through some serious hoops. One easy solution is to set up a direct debit, perhaps choosing a date in early December when you have most money in your account, being sure to check that the payment has gone through. If there's any doubt, check with the GDC before the December 31 deadline.

Indemnity

The other essential thing to have in place is indemnity cover. It is a legal requirement to have this in place so that, God forbid, if any of your patients suffer harm at your hands, they can make a claim and be restored or compensated.

So, why choose indemnity over insurance? Well the simple truth is that the advantages of an indemnity provider over an insurance product are massive. At MDDUS, when you call with a problem or just for some advice you speak to a dentist... a real live dentist, one that's on the GDC register who can actually do dentistry! We are backed up by our own large in-house legal team made up of some of the most experienced medical and dental defence solicitors in the country.

So, if one of our members needs solid legal advice we can provide it quickly and efficiently by discussing the matter with a real practising solicitor. Should a patient raise a claim against you then the dental adviser works with the legal team to resolve the case with your best interests at the forefront of their mind. If one of our members is referred to the GDC, their professional position is defended with, and this bit is really important, no limit to the costs. That's right, no limit to the costs; there's no cap. What you need to defend your position, you will get. Barristers, legal teams and experts can all be really expensive. Compare that to some of the insurance products out there that have a cap on costs and you can sleep easy if you are with MDDUS.

Of course the best advantage of having indemnity instead of insurance is that we provide occurrence-based cover. This means that, provided you were a member when the alleged incident happened, you will have access to assistance. This applies even if you have since left us, or if the accusation is about something that happened many years ago. In contrast, insurance policies generally only provide assistance while you are paying a subscription. If you wish to end your policy you may not be covered for alleged incidents in the past unless you buy what is known as "run-off cover" – often a costly added extra.

MDDUS can also use our

ON

discretion to assist you. If the matter concerning you is something to do with the practice of dentistry then we are most likely to assist. The problem doesn't have to fit a list of predetermined criteria and we are not tied to the words of a contract of insurance which, if it's anything like my home insurance cover, will likely have so much small print and so many exclusions that it's just too much of an effort to make a claim. With us, it's simple: if you've got a problem, get in touch and we will do all we can to help. Now, guess what really helps your defence of a dental matter? Yep, you got it in one… good dental records. Ok I know I promised, but I just can't help myself!

Practical insurance

So what other things do you need to think about before you step out into the big bad world? Well there are some insurance products that might be worth considering. While they are not essential, medical sickness policies which provide you with income if you are off sick, and critical illness policies are both worth investigating.

Lifelong learning

Other things to be aware of include continuing profession development (CPD), another GDC requirement, which runs in five year cycles. Your cycle end depends on the year you register with the GDC. During this cycle you are required to undertake 250 hours of CPD, 75 of which must be verifiable. You should log onto the GDC website and upload your CPD hours annually. At the end of each cycle the GDC audits dentists and may ask for evidence of hours undertaken, so keep your CPD certificates safe.

"Make sure you remain on the General Dental Council register"

Audit requirements are a condition of having an NHS list number in Scotland. Dentists are obliged to do 15 hours of audit or significant event analysis every three years. There are some national projects that can be joined or alternatively do a practice-based audit which will bring about real benefit to you and your practice. Perhaps in record keeping?… Stop it!

It's obviously difficult to predict where we will be in 20 years' time and what professional roles we will be carrying out. Dentistry provides ever-widening opportunities for career development and I do feel that we are lucky to be in this profession. With only a little bit of forward planning and organisation our obligations to maintain our registration can be fulfilled and we can get on with enjoying our career.

Merry Christmas… and don't forget to behave at the practice night out!

Claire Renton is a dental adviser at MDDUS

CRAFTING A PROFESSION

Allan Gaw explores how the efforts of one eminent Victorian helped create modern dentistry

IMAGINE for a moment the world of dentistry without regulation and professional standards. Imagine a trade requiring no academic training or qualifications, a service offered by charlatans and often practised in back streets.

Actually, there is no need to imagine; you only have to glance back through history and look at how dentistry was practised in early Victorian Britain. There were some physicians who performed dentistry, as well as a few semi-qualified individuals, but many of the practitioners would have been uneducated, often largely unskilled, barbers, blacksmiths and mountebanks.

When and why did this state of affairs change? Beginnings are often difficult to define, but there is little dispute that we owe the creation of modern dentistry as a profession to one man born 200 years ago this year: Sir John Tomes.

A research interest in teeth

Tomes was born in Gloucestershire three months before the Battle of Waterloo in 1815 and began his training as a doctor when, at the age of 16, he was apprenticed to an apothecary and subsequently became a pupil at King's College and the Middlesex Hospitals. As a medical student, his main interest became the structure and function of teeth, and at the age of only 23 he presented his initial research findings to the Royal Society. Just eight years later he would be invited to become a Fellow of this august body.

After he had decided to focus on dentistry rather than medicine, he established his practice in London and was appointed surgeon-dentist to King's College Hospital. At the time, like everyone else, he needed no specific qualification or evidence of training to set himself up as a dentist.

His research continued and his work on dental anatomy has left us with three eponymous structures: the Tomes' processes of the enamel forming ameloblast, Tomes' granular layer (a narrow layer of dentine adjacent to the cementum) and Tomes' fibrils (processes of odonotoblasts lying within dentine tubules).

His scientific reputation and his ongoing association with the Royal Society and its fellows meant he was well placed to help modernise the practice of dentistry – the necessity of which was in no doubt. In addition, his skill and reputation meant that his patients were often from the top tiers of society, which further afforded him considerable influence in his endeavours.

Birth of a profession

Tomes was a founding member of the Odontological Society of London, established in 1856. This was a forum for the exchange of scientific ideas and the sharing of best practice. It would also become a lobbying force seeking the recognition and protection of dentistry as a profession, and Tomes would serve as the President in 1862 and 1875.

Its members were aware that dentistry could only come of age when the public had confidence in it as a profession. They also knew that a profession requires a recognised training programme, a set of standards against which the competence of its members may be judged and a governance body to uphold and enforce these standards.

Tomes and his like-minded colleagues began by defining the training necessary to become a dental surgeon. This involved two important developments. First, there was a need for a dental hospital with a prescribed course of training where students could attend lectures and receive tuition while treating patients. Thus, the Dental Hospital of London in Soho Square was established in 1858, and one year later the London School of Dental Surgery was opened on the same site. The hospital later moved in 1874 to a larger site in Leicester Square to become The Royal Dental Hospital of London where it would receive patients for the next 111 years.

Tomes was the first clinical demonstrator in the new hospital, which proved to be very popular with the public – its annual reports record that over 2,000 patients attended in 1859 and more than 22,000 operations were being carried out annually by 1872. Perhaps one of the main reasons for this popularity was that conservative treatments were being offered at a time when extraction was often the only therapeutic option available.

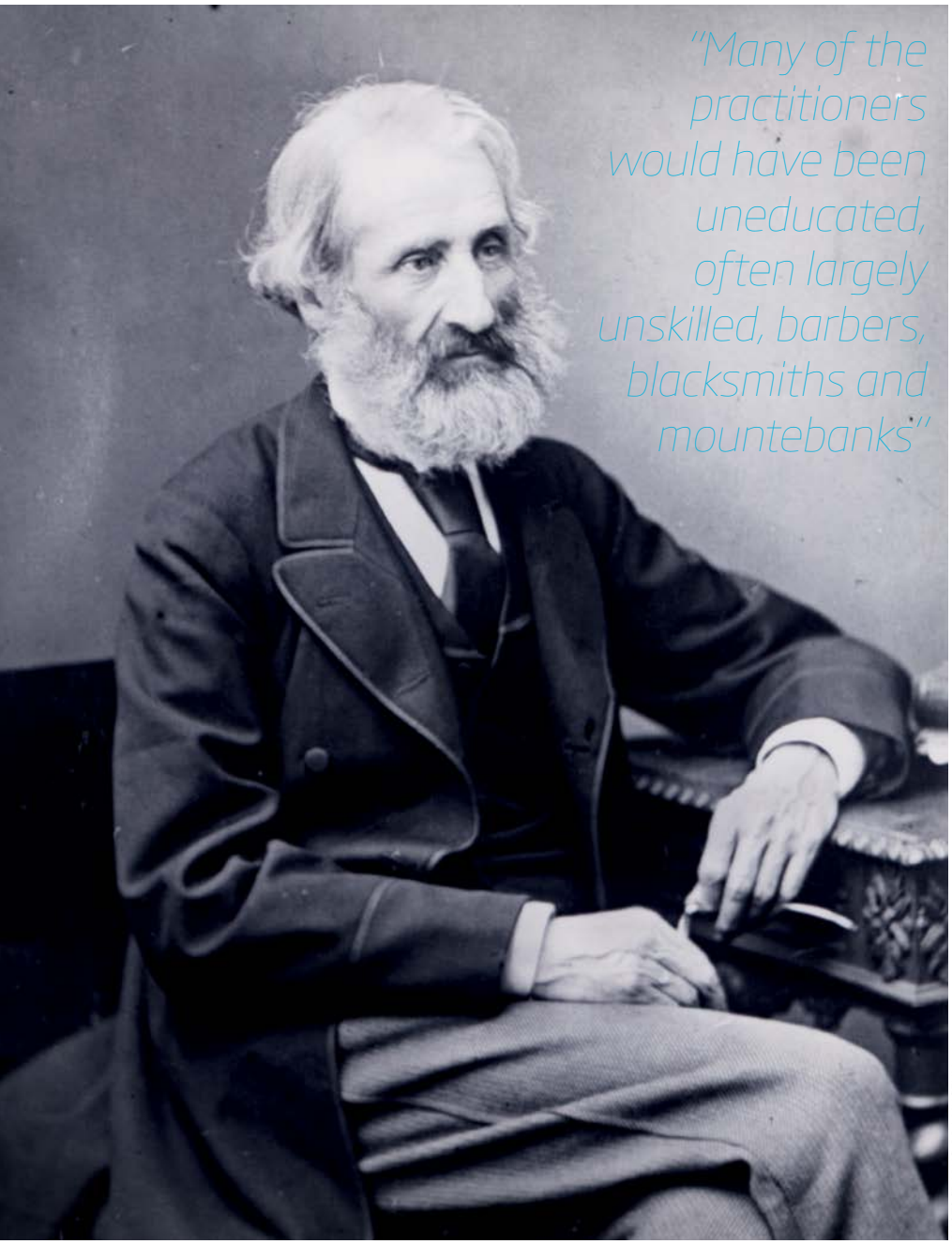
A contemporary account of the work and training in the hospital was published in the *British Journal of Dental Science* in 1865:

"watch in turn the nine or ten chairs, attended to by careful earnest students, working to the benefit of the poor patients with as much zeal and care as if they were to receive a five guinea fee for each stopping, never attempting more than they feel themselves competent to accomplish, and at any moment of the day, so that at no time is the poor patient the victim of inexperience or experiment".

But, while this was regarded as an important foundation to dental training, it was in itself considered insufficient. Dentistry was a branch of surgery and Tomes and the Odontological Society sought to have this recognised. After two previous unsuccessful attempts, they finally succeeded in obtaining a Royal Charter that allowed the Royal College of Surgeons of England to award a Licentiate in Dental Surgery (LDS) in 1858.

Tomes had been lecturing on dentistry since 1845 at the Middlesex Hospital and now he drafted the curriculum for students taking the new LDS examination and became an examiner for the first sittings in 1860.

This was a strategic triumph. By aligning themselves with the long-established and powerful Royal College of Surgeons, dentists had instantly raised the status of their profession and simultaneously



Clockwise from left: Sir John Tomes; the Tomes medal, awarded for outstanding service to the dental profession; an instrument table designed by Sir John

PHOTOGRAPHS: BDA MUSEUM

provided their patients with greater confidence in their abilities.

Thus, by the 1860s, dentists had a professional framework of training and accreditation, but it still lacked a governance body. This was next on Tomes' agenda.

An end to backstreet dentistry

In the 1870s, Tomes and his colleagues formed the Dental Reform Committee, which lobbied parliament and called for protective legislation. After much discussion and a series of compromises to satisfy the concerns of both physicians and pharmacists, who both felt they had a role to play in the provision of dental services, the Dentists Act became law in 1878. This was the first legislation to control and restrict the practice of dentistry to qualified dentists. As part of this new law, a Dentists' Register was established the following year and only those listed on the register could use the protected titles 'surgeon dentist' or 'dental surgeon'. John Tomes' name was the first to be listed on the new register as a mark of recognition for all his work in pushing forward the agenda of professionalisation.

The Dental Reform Committee was also aware that a professional body was needed to police and enforce the new legislation, so in 1879 they called for a nationwide meeting to establish the British Dental Association. Formally established the following year, the BDA duly elected John Tomes as its first president and he was knighted in 1886 "for eminent services rendered to his profession". During its early years, the BDA devoted much of its time and efforts to prosecuting those practising dentistry in breach of the Dentists Act.

The crafting of a new profession, which involved a journey from backstreet jobbing dentistry to a respected surgical specialty, had taken less than three decades and had been in large part the project of one man – Sir John Tomes. The professionalisation of dentistry that he led has left a remarkable legacy. The current President of the British Dental Association, Professor Nairn Wilson, has said: "... in the 120 years since [Tomes'] death Britain's oral health has been transformed. And that's thanks to the skill and dedication of the dentists who have followed in his footsteps."

Sources

- Royal College of Surgeons
- Dictionary of National Biography
- British Dental Journal 218, 270-1, 2015

Dr Allan Gaw is a clinical researcher and writer in Glasgow

TREATMENT

ROOT FRACTURE

DAY ONE
Mr F attends his dentist – Dr K – complaining of a tender upper premolar at UL4. On examination it is found that the tooth has fractured. Six months previous Dr K had root-treated the tooth which had been giving Mr F problems for the last couple of years. It had been filled twice but with recurrent infections requiring antibiotics.

DAY 5
The patient re-attends the practice and the two root canals at UL4 are located, gutta-percha (GP) removed and dressed with Ledermix. However, after two days Mr F is back in the surgery with the tooth now very tender to touch. The canals are opened and blood is found to be oozing from the buccal canal. Dr K leaves the tooth open to drain and prescribes antibiotics.

DAY 27
Mr F calls in sick from work with an "agonising" toothache and makes an emergency appointment with Dr K. The dentist informs the patient that the tooth is chronically infected and needs to be extracted. This is done with the patient's consent and the procedure is routine with no complications noted in the patient records. No post-extraction radiograph is taken.

Two years later
Having moved to a new town Mr F registers with a local dental surgery and attends complaining of pain around UL4. The new dentist takes a radiograph and this reveals the presence of a retained root at UL4 which has become infected. Three days later the root fragment is surgically extracted.

A YEAR later Dr K receives a letter of claim from solicitors representing Mr F alleging negligence in the treatment of the patient's tooth. In particular the letter states that the dentist failed to protect the root-treated UL4 by means of an onlay or crown to prevent fracture. It further alleges that the dentist failed to record the fracture of the root and to inform Mr F what had happened. Nor did Dr K take a post-extraction radiograph and carry out remedial treatment to remove the retained root, or refer appropriately.

Dr K contacts MDDUS and an adviser reviews the letter of claim and patient records along with the dentist's account of the treatment. An expert report is commissioned from a GDP and lecturer in restorative dentistry. The expert offers an opinion on each of the allegations.

In regard to failure to protect the root-treated tooth from fracture with an onlay or crown he states that the need for such a measure is determined by the size of the cavity in the tooth and degree of occlusion. In his opinion there is no evidence to conclude UL4 was at risk of fracture so it cannot be said that placement of an onlay or crown was essential.

The expert reviews radiographs taken by Mr L's current dentist and notes the presence of a retained root prior to its extraction. Nothing in the notes recorded by Dr K shows that he was aware of the retained root. The expert expresses the view that there was no breach of duty in a root fracturing during extraction and remedial treatment being required. Such an occurrence is always possible even when appropriate skill and care is taken during an extraction.

However, he believes the size of the root fragment was such that Dr K should have been aware it was there and further confirmed by a radiograph. A decision could have been made then either to remove the fragment or delay for a surgical procedure to be carried out on a later day either by Dr K or with referral to a specialist. The expert states that in his opinion this failure did constitute a breach of duty of care.

In regard to causation the expert states that in his view there is no claim in regard to the loss of UL4 or for the value of any prosthetic replacement. But the need for a later surgical procedure and the discomfort associated with this and the infection caused by the root fragment could have been avoided.

In view of the potential weaknesses in defending the case MDDUS decides with the agreement of the dentist to settle the claim with no admission of liability.

Key points

- Ensure that any extracted teeth are carefully examined for potential retained fragments.
- Add clinical justification in the notes for all key clinical decisions.
- Complications during clinical procedures do not necessarily constitute negligence if appropriate skill and care have been taken.

OUT THERE

MOUTH MYSTERIES A whole slice of gherkin, sprouting tomato seeds and sweet wrappers are just some of the bizarre items found in patients' mouths by UK dentists. Research by Clinic Compare also revealed one patient's mouth covered in toxic superglue where she had tried to reattach a crown.

SPORT ROT Exercise could be bad for teeth. Researchers at University Hospital Heidelberg, Germany, noticed the longer athletes trained the less saliva they produced and the more alkaline it became. This encouraged the growth of plaque bacteria, increasing the chances of decay. They went on to admit, however, that the link between the hours of training and decay "was not strong enough to imply causation."

MOLES FOR MOLARS Life was tough for 18th century moles. The mammals' feet were thought to hold curative properties for various human ailments including toothache. The hairy, long-clawed amulets were often carried in pockets or hung on a mantelpiece to ward off dental pain. The superstition can be traced back to the first century but no explanation is ever given as to its origin. Source: ***Science Museum London.***

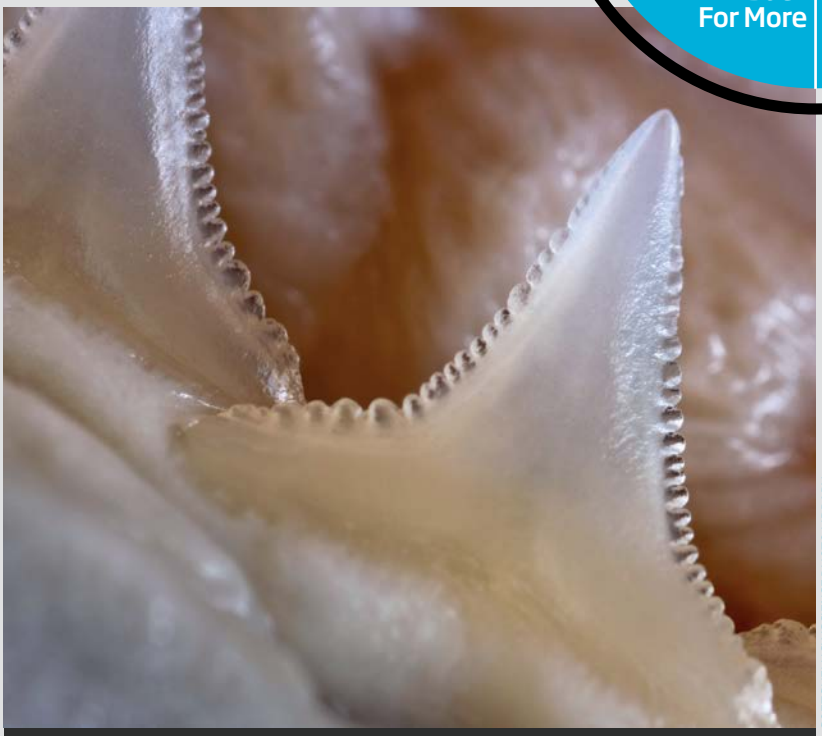


PHOTO: PASCAL GOETGHELUCK/SCIENCE PHOTO LIBRARY

NAME THAT BITE

Stumped? The answer is at the bottom of the page

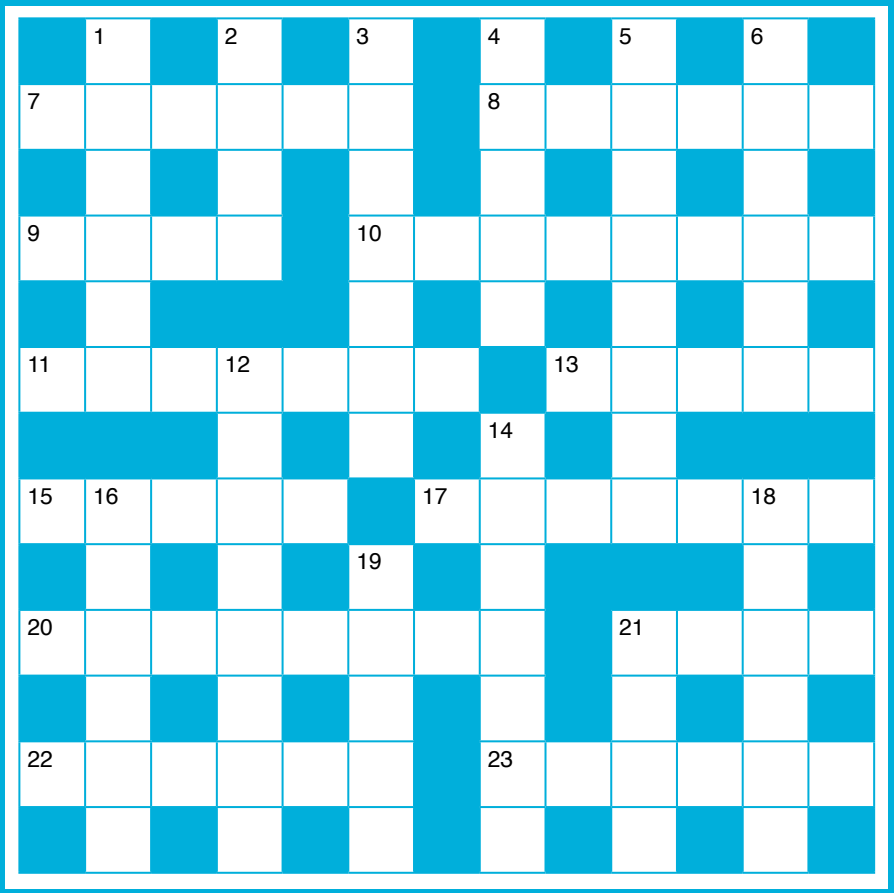
CROSSWORD

ACROSS

7. Of the middle line (6)
8. Stay (6)
9. Potential poison in denture adhesive (4)
10. Looseness of teeth (8)
11. Reduce level of strength (7)
13. Repeated series (5)
15. European island nation (5)
17. Beer variety (4,3)
20. Logo (8)
21. Unruly crowds (4)
22. The art of film (6)
23. Nerd (6)

DOWN

1. Catlike (6)
2. Frisbee (4)
3. Fleetingly see (7)
4. Blunt-ended surgical instrument (5)
5. Staff member (8)
6. Opposite of proximal (6)
12. Orthodontic device (8)
14. Relating to the roof of the mouth (7)
16. The BBC (6)
18. Of the lips (6)
19. Indirect restoration (5)
21. Vocalisation of 1 Down (4)



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

NAME THAT BITE? *Shark teeth*

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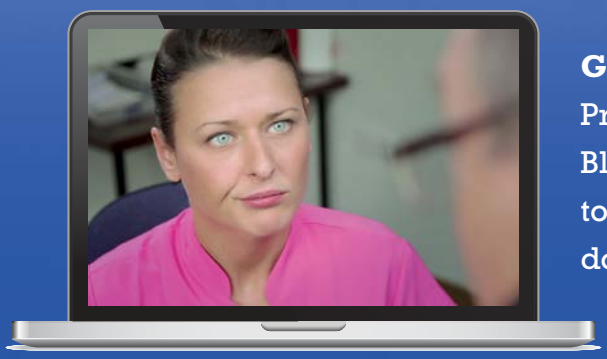

GP TRAINING TOOLS

Practices have access to our risk drama series Bleak Practice, which can be used to bring risks to life during your team PLT. Each episode has a downloadable discussion guide.

For further information email: risk@mddus.com
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