



PICKING UP THE

PIECES

HELPING NEW PATIENTS WITH EXTENSIVE TREATMENT NEEDS

ALSO INSIDE

05 BIGGING UP THE CV
RISKS IN STRETCHING THE TRUTH

10 ORAL CARE IN PRISON
PROMOTING INCLUSION

AN MDDUS
PUBLICATION





Welcome to your **SoundBite**

THE first interaction with any new dental patient can present numerous challenges – particularly in those with extensive treatment needs and possibly due to sub-standard care and/or supervised neglect from another dental care practitioner. On [page 8](#), I offer some advice on “picking up the pieces” without being bounced into any injudicious commentary.

Can encouraging vulnerable patients to improve their oral health bring positive outcomes in other aspects of their lives? Professor Ruth Freeman certainly believes so and has been working on projects with prisoners and the homeless in Scotland, linking oral care and social inclusion (see [page 10](#)).

In this issue we also offer some clarity ([page 4](#)) on crucial differences between indemnity and insurance – and the “gold standard” offered by MDDUS – as more providers enter the market.

On [page 5](#) Liz Price offers some cautionary tales on “bigging up the CV”, and Janice Sibbald also urges caution in using Google to assess potential job applicants on [page 6](#).

Dental business coach Alun Rees gives some practical advice on [page 7](#) on avoiding the pitfalls of embracing new products, and on [page 13](#) we look at how the #metoo movement has highlighted the importance of not just ignoring inappropriate behaviour at work.

Former dental core trainee Kuljit Kaur offers a personal view on managing the transition from maxillofacial surgery back to dentistry on [page 12](#), and our case study on [page 14](#) concerns an accusation of substandard root canal treatment and the value in keeping a clear and comprehensive record of patient discussions.

• **Doug Hamilton**
Editor



INVOLVE DENTISTS IN WIDER DISEASE PREVENTION

DENTISTS could play a much wider role in detecting health conditions such as diabetes and cardiovascular disease, says the Faculty of Dental Surgery.

The FDS has published a Position Statement on oral health and general health suggesting that dentistry could be better utilised in the diagnosis of certain wider health problems and also in providing preventative health advice.

Professor Michael Escudier, Dean of the FDS at the Royal College of Surgeons, said: “Good oral health is essential for our overall wellbeing. In recent years there has been increasing evidence of the link between oral health and general health. Dentists and other members of the oral healthcare team always inspect a patient’s mouth in the course of treatment. This provides them with an opportunity to monitor, on an ongoing basis, how their patient’s health is changing.

“While checking a patient’s oral health, they can look for relevant signs of other conditions – chronic gum disease can be an indicator of diabetes and cardiovascular disease, for example. They can also offer advice on what dietary and lifestyle changes patients could make to improve their overall health, which can also help to prevent conditions such as obesity and oral cancer.”

The FDS is recommending specifically that oral health should be included in the government’s upcoming Green Paper on Prevention due to be published later this year. It believes that dentists should be involved in all national and local public health campaigns and in the delivery of health and lifestyle advice.



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ARF OPENS FOR DCPs

THE annual renewal period has opened for dental care professionals (DCPs) in the UK.

DCP registrants have until July 31, 2019 to renew in order to remain on the General Dental Council (GDC) register.

- They must:
- pay the Annual Retention Fee (ARF)
 - make an annual continuing professional development (CPD) statement (or

end-of-cycle statement if their five-year cycle ends on 31 July)

- declare they have, or will have, appropriate indemnity in place.

This is the first year DCPs are required to make enhanced CPD statements.

The quickest way to renew is through eGDC on the GDC website.

DENTISTS SHOULD SELF-AUDIT ANTIBIOTIC PRESCRIBING

DENTISTS are being encouraged to audit their prescribing practices in a bid to reduce the use of antibiotics.

They are also being encouraged to raise awareness of issues around antimicrobial resistance amongst patients by placing leaflets and posters in waiting rooms.

The call came in a statement from dean of the Faculty of General Dental Practice (FGDP (UK)) Ian Mills.

He acknowledged the pressure dentists often face to prescribe antibiotics, particularly in dental emergencies. Patients, he said, often expect "instant solutions and quick fixes" and are keen to avoid surgical intervention "if at all possible".

New figures from Public Health England (PHE) show antibiotic-resistant bloodstream infections increased by just over a third between 2013 and 2017. And in just over 30 years, antibiotic resistance is predicted to kill more people worldwide than cancer and diabetes combined.

PHE has committed to a campaign to raise awareness amongst the general public of the need to 'Keep Antibiotics Working'.

Dentists issue around five to seven per cent of all antibiotic prescriptions in the NHS.

Ian Mills said: "A simple first step to reducing prescription rates may be to audit current practice including details of patients presenting with specific clinical conditions and the action in relation to prescription."

Useful links

- FGDP (UK) Practice self-audit tool - www.fgdp.org.uk/antimicrobial-prescribing
- CPD from British Association of Oral Surgeons - www.baos.org.uk/elearning



DIRECT LINK BETWEEN FRAILITY AND ORAL HEALTH

FRAIL older people have a much greater risk of oral health problems, according to new research.

Those with muscular weakness, sudden weight loss or impaired mobility are more likely to experience problems, such as difficulties in biting and chewing food, and sensitivity to hot and cold foods and drinks.

The investigation published in the *Journal of Gerodontology* also found a connection between frailty and speech difficulties, as well as a greater likelihood of taking oral pain medication.

The study examined a large number of hospitalised elderly patients over a six-month period. It found that frail adults are more likely to feel self-conscious about their teeth, gums or dentures. They are also unhappy with how their teeth look, yet access dental care less often.

Figures show that in the UK more than five million people aged over 65 experience significant health problems.

Dr Nigel Carter OBE, Chief Executive of the Oral Health Foundation, said the oral health of older people remains an ongoing issue.

He said: "In the UK, people are living longer than ever before. This will increase the amount of poor health, frailty and disability. In turn, it will create a series of challenges for how we care for the population's oral health."

He said problems often begin with a loss of dexterity and that limited mobility, no matter how small, can have a considerable negative impact on people's ability to carry out even basic oral health tasks, such as toothbrushing.

Maintaining balanced nutrition has also been shown to be more difficult, he said, which often leads to more frequent sugar consumption. Those with health problems are also more likely to be on medication which can make conditions such as dry mouth more common.

Dr Carter called on the government to be more proactive in improving the provision of oral healthcare for older people, including offering dental services in hospitals, residential homes and in patients' own homes.



MOST UNDER-ONES DON'T ATTEND DENTIST

ONLY three per cent of under-ones in England attended the dentist and in some regions it was than less one per cent, research from Birmingham University has found over the 12 months to June 2017.

The British Dental Association (BDA) said the figures are indicative of a failure from successive governments to offer a joined-up approach to the oral health of children in England. The BDA supports the idea of getting children to a dentist early, to encourage good habits and embed a preventative approach. It has called for a concerted approach covering primary schools and nurseries, GPs, health visitors and other care providers.

BDA chair Mick Armstrong said: "We need real engagement in schools and nurseries, and Scotland and Wales are already leading the way. Kids in England deserve better than a second-class service."

THE GOLD STANDARD

Dentists may believe that indemnity and insurance products are all the same – but there are some crucial differences

EVERY dentist must have it, but there is currently lively debate as to exactly what kind of indemnity product is best.

With so many conflicting reports out there, it can be difficult for even experienced clinicians to access accurate information about the pros and cons of each product type.

Fortunately, MDDUS' dental members enjoy comprehensive protection that is competitively priced. Our occurrence-based indemnity offers more than just cover for negligence claims, it offers lifelong peace of mind. We believe it's the gold standard, with a personal service from a team of experienced dental and legal advisers who are available 24/7 to assist any member in professional difficulty.

We offer breadth and depth of experience in defending members successfully before the General Dental Council and in negligence claims. We use discretion positively to provide assistance and meet claims that an insurer might very well turn down.

It is imperative that patients have access to redress when things go wrong. Our occurrence-based indemnity has no time limit or cost cap on liability. This means that we can help members for any claim that arises, even if they have moved abroad, ceased clinical work, retired or are deceased when the claim or complaint arises. This has to be the safer option – for professionals and patients alike.

And increasing numbers of dentists agree. Last year, MDDUS dental membership in England, Wales and Northern Ireland rose by almost a third, while total dental membership

in those countries has doubled since 2015. In England alone, our dental membership jumped by more than 40 per cent in 2018 compared to the previous year.

Market share in Scotland stands at approximately 70 per cent and is now above 20 per cent elsewhere in the UK and growing fast.

MDDUS Head of Dental Division Aubrey Craig believes this sustained growth is built on a firm commitment to quality and an indemnity model that provides comprehensive protection.

He said: "Increasing numbers of dentists are putting their trust in our professionalism, responsiveness and value in an increasingly tough environment where claims and GDC referrals continue to rise.

"We believe that members benefit by having their case managed by the same team of expert advisers however the case evolves, rather than being passed from one to another and on again as a complaint changes to a claim, a GDC case or an inquest/fatal accident inquiry."

Dentists won't have failed to notice that GPs in England and Wales joined the state-backed indemnity schemes, CNSGP and GMPI on 1 April, but there are many risks these new government schemes won't cover. Doctors within the schemes will still need MDDUS membership for advice on complaints and ethical dilemmas, and claims arising from non-NHS work. We will continue to offer legal representation at inquests, GMC hearings and disciplinary investigations. Such situations can seriously impact upon the reputation and

career of any professional and could ultimately result in being struck off.

There has been no appetite in the NHS for extending these schemes to dentists. We understand, with our experience in dealing with claims against dentists, that it is often difficult to separate which treatments in the same tooth were carried out under the NHS and which were paid for privately. This is a level of complexity that simply does not apply in the new GP schemes, making it unlikely that the Government will extend the schemes to dentists, given the relatively low-value claims involved.

Alternative commercial insurance products are becoming more widely available, but dentists must be sure of exactly what will – and won't – be covered. Unlike insurers, we're not in it for the profit, we have no small print to hide behind and we provide greater protection than the commercial alternatives available.

Typically with a claims-made product, you are transferring the risk to your insurer one year at a time, until you retire. If you simply want to change back to a traditional indemnity provider, you will either have to buy potentially expensive "run-off" cover or take on the risk of any unknown claim personally.

The benefit of our occurrence-based product is that you transfer the risk to us permanently, no run-off cover is necessary. Yes, it may be more expensive than an insurer in the short term, but you buy lifetime peace of mind.



'BIGGING UP'

THE CV

It may be tempting to stretch the truth in CVs, job applications and interviews – but the consequences can be severe



COMPETITION for prime positions in dentistry can be fierce so it is natural to want your CV to stand out from the crowd. However, it is important to resist the temptation to “big-up” a CV with exaggerations, outright lies or half-truths in order to enhance your chances.

Honesty and trust are at the very heart of professionalism and yet MDDUS case files feature numerous examples of healthcare professionals falling foul of this when constructing their CV. This can result in disciplinary or regulatory difficulties, or even potential patient safety issues.

Here are a few examples:

- A dentist claimed vast experience in cosmetic dental treatment and gained a much sought-after position in a general dental practice. However, it soon became evident that her skills were not as described. Her contract was terminated and she was investigated by the General Dental Council (GDC).
- A dentist claimed to have published papers in a journal which was subsequently found not to exist. He also claimed vast experience in oral surgery when he had quite limited experience. He was suspended from the GDC register.
- An SHO claimed that he had done many complex procedures on his own in his previous hospital when that was far from the truth. He soon ran into difficulties and further information was sought from his previous employer which revealed the reality of his experience. He faced both disciplinary and regulatory investigations.
- A dentist submitted a colleague's work as her own as part of her postgraduate diploma requirements and added the qualification to her CV. She was suspended from the GDC register.

Similar examples can be found in other healthcare professions.

“Bigging up” a CV is not just limited to job applications. Sometimes the information provided to a patient can include an exaggeration of the clinician's qualifications or experience.

For example, in order to persuade a patient of his expertise, one dentist stated that his diploma in implant dentistry was “gold standard” for training and the “highest postgraduate qualification”, when that was clearly not the case. He faced a GDC investigation.

Similarly, there is potential for a GDC investigation if a dentist uses the title “specialist” or describes themselves as a “specialist in...” when not included on the relevant specialist list. The GDC is clear that dentists who are not on their specialist list must not use titles which may imply specialist status, such as orthodontist, periodontist, endodontist and so on.

The same rule applies to dental care professionals (DCPs). There is currently no specialist list for DCPs, so the GDC warns they must not “mislead patients” by using titles which could imply specialist status, such as “smile specialist” or “denture specialist”.

Practitioners who are not on a specialist list may use the terms ‘special interest in..’, ‘experienced in..’ or ‘practice limited to..’.

Even what might be considered by some to be minor exaggerations can lead to investigation and possible sanctions.

The GDC's guidance *Standards for the dental team* states: “You must justify the trust that your patients, the public and your colleagues have in you by always acting honestly and fairly in your dealings with them. This applies to any business or education activities in which you are involved as well as to your professional dealings.

“You must make sure you do not bring the profession into disrepute. You must make sure that any advertising, promotional material or other information that you produce is accurate and not misleading, and complies with the GDC's guidance on ethical advertising.”

The GDC expands on this further in its

indicative sanctions guidance:

- “Patients, employers, colleagues and the public should be able to rely on a dental professional's integrity.”
- “Dishonesty, particularly when associated with professional practice, is highly damaging to public confidence in dental professionals as it undermines the trust that the public are entitled to have in registrants.”
- “Serious dishonesty in professional practice may include: ... submitting or providing false references; ... providing inaccurate or intentionally misleading information on a CV or other formal document..”

Although aimed at medics, the General Medical Council has equally pertinent advice in *Good Medical Practice* which states that doctors “must always be honest” about their experience, qualifications and current role, and when advertising services, they must make sure the information they publish is “factual and can be checked, and does not exploit patients' vulnerability or lack of medical knowledge”.

Put simply, as with everything in life, honesty is the best policy. MDDUS has dealt with numerous cases of members facing regulatory or local disciplinary proceedings in regard to falsely claiming qualifications and experience in CVs or interviews.

The consequences of misleading or dishonest behaviour can be severe and could involve not only the employer but also the GDC. In such situations, sanctions can range from warnings to erasure.

ACTION POINTS

- Avoid the temptation to stretch the truth in CVs, job applications and interviews.
- Be certain the information provided in these contexts can be independently verified.

Liz Price is senior risk adviser at MDDUS

EMPLOYERS are increasingly using social media as part of their recruitment process and to advertise roles. There are many ethical and legal aspects to this but it is essential that prospective candidates and medical and dental practices move with the times and are aware of this additional tool in the recruitment of staff.

E-recruitment - or using the internet to aid conventional recruitment processes - has a number of advantages. It is particularly appealing to so-called 'millennials' who have grown up using a wide variety of social media platforms. E-recruitment also has the advantage of attracting the attention of "passive" job seekers, i.e. those who are currently employed but are open to learning about new job opportunities.

But there are also some risks to both employees and employers.

Here comes the rain...

When was the last time you actually "Googled" yourself? The last time I did I found my Twitter account was open, there was a video of an Annie Lennox song being murdered by me on karaoke, along with many personal pictures of my family. I had no idea how they had got there and certainly hadn't given my permission

DIGITAL

for them to be there. Any potential employer would know I was a mother of two children (with questionable music taste) among other details. Would this have made a difference to any job I might apply for?

Your social media footprint is the trail that you leave behind for others to find every time you upload a photo on Instagram, check in on Foursquare, share anything on Facebook, tweet on Twitter, pin on Pinterest boards, publish videos of yourself on YouTube, get tagged in a Flickr photo or add jobs and education info onto a LinkedIn profile.

Our advice to practices previously has been never to use the internet as part of recruitment and selection processes - this for a variety of reasons. However, we do know from feedback from our members that this advice is frequently ignored in reality! An ACAS survey in 2013 established that the vast majority of employers did not have a formal policy covering the use of social media when recruiting staff.

Ask some questions

First, have you asked for permission or are the candidates even aware that you will be carrying out a search on them? Although not



Employment law adviser **Janice Sibbald** urges caution in using Google to assess potential job applicants

FOOTPRINTS

legally necessary, it would be good practice to let them know that this is a part of your recruitment process. More and more employers use online sites to check if there is a reason to believe that a candidate is not being truthful in their job application.

Secondly, could this open the practice up to potential discrimination claims? For example, if a candidate was open about their sexuality on their Facebook profile and they knew you had viewed this, they may challenge whether this was the reason that they were unsuccessful in applying for a role. The skills and experience that a candidate has in relation to the job description is primarily what a candidate should be assessed on. The Equality Act 2010 protects candidates from discrimination on grounds including age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex or sexual orientation.

Relying on social media or Google may also mean you are not reaching potentially good candidates who do not have ready access to computers or use social media. Is it fair to compare candidates by looking at those who do have social media profiles against those who do not? It is also worth noting that if you are

recruiting low-skilled workers they may be less likely to use social media in their current roles or have access to it at home.

Other disadvantages include doubt over whether the information an employer finds online is actually accurate in the first place, and also perceptions of invasion of privacy by the applicant who may feel that it is unfair for you to access any online information about them. The least risky approach would be to refer only to sites such as LinkedIn, which are widely accepted as professional networking and job-hunting sites.

To conclude, we suggest that great care is taken when using social media in recruitment. Employers are advised to provide relevant training and information to managers who use social networking for recruitment, and in particular it is important to ensure that all information gleaned about candidates is accurate and handled in a responsible way.

If you wish any further information on this please contact MDDUS employment law advisers on **0333 043 4444**.

Janice Sibbald is an employment law adviser at MDDUS

DON'T BELIEVE THE HYPE

Dental business coach **Alun Rees** offers practical advice on avoiding the pitfalls of embracing new products

IN EARLY 1985 my principal suggested that I try a new composite for anterior restorations that a company salesman had shown him. In those days there were only two brands of composite and both came in one shade, "universal". This market newcomer looked attractive, handled well, finished nicely and seemed to match shades adequately. At first I was happy. A month later patients started showing me the "brown fillings" in their front teeth. In those less litigious days no serious damage was done and I went back to my tried and trusted material.

For the rest of my clinical career I was wary of new materials, especially composites, and never fully trusted that particular company's sales claims.

Hype is defined as "the promotion or publicity of a product or idea intensively, often exaggerating its benefits". Of course manufacturers and their sales representatives will push their claims for new products. Sales people have to justify their existence and manufacturers need to recoup investment costs.

There have always been advocates of new products. Traditionally they were from academia or specialist practice and were objective and neutral. Over recent years a new phenomenon has emerged. In the same way that "influencers" are widespread on social media, so their use is growing in dentistry. These so-called "key opinion leaders" or "clinical salespeople" are highly paid and try to influence clinical practice. Frequently they are charismatic speakers who appear credible, but you must ask: "Who is pulling their strings?"

Of course there are exceptions. As hard as it seems to believe, "father of dental implantology" Per-Ingvar Branemark took more than 20 years from his early successful experiments with implants to reach even initial acceptance. His reports of the phenomenon of osseointegration were initially treated with ridicule by some.

Here are my suggestions on how to deal with the new "big thing". **Remember you're a scientist.** Examine all claims in the cold light of evidence. Learn how to read research papers and remain slightly sceptical. If something seems too good to be true, it probably is.

Neither first nor last. There are some people who adopt change and embrace the new for its own sake; let them make the first mistakes. On the other hand, don't be so entrenched that you never grow or adapt new ideas. That path leads to professional stagnation.

Choose your gurus. Influencers are not necessarily independent, so

consider their motives. What's in it for them? Who is paying their bills? Treat with caution someone who only shows you their successes and apparently "never" makes mistakes.

You decide. Practise using something new. Read the data and instructions. Choose your first case carefully and review the results. If necessary, invest in a course that will teach you how to use the material, technique or equipment properly.

Start small. I was once advised to "never bet the ranch" on something new. These were wise words. Learn to walk before you try to run. If you feel something new may have several applications, get familiar with its main function before expanding in other directions.

Have a way out. Mistakes will happen. Be prepared and have a plan for what to do should something fail to perform as you hoped.

Economics is a science too. If you are persuaded that having a new piece of equipment will "pay for itself" in use, ask yourself whether you will need to change your prescribing pattern in order to afford it. Is the use justified on economics alone?

Can your laboratory cope? When starting something new, ensure that everyone can deal with the processes and consequences - don't presume. Check first that the laboratory are familiar with the technique/material, are happy for you to use it and can give the support you need.

Learn to say "no". We all have to work outside our comfort zone sometimes, but to work without a safety net is asking for trouble. Of course bigger cases bring bigger fees, but they also leave you further to fall at greater cost.

Be humble. If something has failed then accept the fact. Analyse what has gone wrong, remedy it where possible, learn from the experience and move on. Don't be tempted to blame anything or anybody else; you are at the sharp end and are responsible to the patient. Be prepared to remedy the situation at your own expense; consider it an investment in a lesson hard learned. It may be worth seeking advice from your dental defence organisation.

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



PICKING UP THE

Treating new patients with extensive treatment needs poses many challenges for dentists. *SoundBite* editor **Doug Hamilton** offers practical advice

THE first interaction with any new dental patient can present numerous challenges, but these can be particularly acute with a patient with extensive treatment needs. These patients may have poor oral health for various reasons, whether it's through a prolonged lack of self-care or perhaps due to sub-standard treatments and/or supervised neglect from dental care practitioners.

These patients may also attend with dental anxiety, which will likely be heightened by the unfamiliar surroundings. The resulting tension can lead to communication issues, which hinder the essential consenting process and can in some cases lead to distrust.

Differing treatment plans

A common trigger for a dispute is the presentation of the new treatment plan. In particular, patients who have been used to years of "light-touch" dentistry rarely take kindly to being advised that they now have extensive treatment needs.

Of course, the disparity between current and historical treatment recommendations could arise from lifestyle changes, bad luck or simply differences in clinical opinion. However, on occasion, the new patient may have been on the receiving end of sub-standard treatments and/or supervised neglect, which in turn will necessitate extensive remedial work. In these circumstances you, as the new dentist, are faced with the twin problems of identifying an appropriate management strategy and explaining to the (rather upset) patient what has gone wrong.

Initial assessment

The obvious starting point is to conduct a standard, comprehensive examination which should allow the construction of a complete clinical picture. Depending on your findings, you may then decide that additional investigations are warranted, for example, teeth may be vitality or percussion tested. Additional radiographs may be justified or even onward referral. Each of these measures must be carried out with the patient's informed consent and be carefully recorded.

Once the full extent of the presenting problems has been assessed, a suitable explanation must be offered to the patient. This can be a fraught conversation. Some patients may be highly sceptical, believing that they are being fed scare stories in order to optimise revenue. With little in the way of an existing working relationship, it can be difficult to convince these patients (even after the offer of a second independent opinion) that you are providing a genuine account of your clinical findings. Conversely, some patients returning to your practice after a long absence may already have had reservations regarding your predecessor (which is why they moved in the first place). Often they will attempt to recruit you as their advocate in the fight against the last 'bad guy'.

Explaining your findings

Charting a course through these troubled waters is rarely easy and it is important to convey your advice in a neutral, empathetic manner. It is not your job to pass judgement on the patient's previous dentist or whoever was responsible for poor treatment. Equally, you are not obligated to try to persuade the patient to engage with your recommendations.



It is advisable to provide a comprehensible and professional account of the identified issues, their potential ramifications and the relative merits of all viable management options. This last point leads us into two further areas of contention.

It is critically important to recognise the limitations of your own clinical skills. Logic and common sense suggest that it may be harder to replace, for example, a failed root filling than carry out primary endodontics. If the task seems to be at the limit of your experience, referral to a specialist may be the appropriate way forward.

This approach will incur additional expense which can be problematic for those patients who believe that they have been/are being ripped off. But it is important to stand by any decision that the involvement of someone with greater expertise is appropriate.

Avoid patient-led treatment

This firm yet compassionate approach has wider applications. Patients, perhaps in their desperation to avoid tooth loss, may pressure you to undertake treatments that you believe simply will not work. The voice inside your head is telling you to decline but a misplaced sense of obligation may tempt you to agree. This way madness lies. Patients are entitled to make an informed choice from a list of justifiable, appropriate options (including non-intervention or deferred treatment). They are not entitled to treatment which you do not believe to be an appropriate or justifiable option. If the patient continues to insist on treatment you believe will not work, inform them clearly of the reasons

PIECES



why not (and carefully document your discussion) and advise them of their right to seek a second opinion.

Complaints

It is fair to say that disappointed patients are more likely to complain. They may accuse their dentist of creating a treatment plan that prioritises commercial interests. If so, it is worthwhile providing further clarifications and reassurances. If these are not sufficient, you should be able to successfully defend a complaint provided you have made a comprehensive and logical assessment and taken thorough notes.

Alternatively, patients who are alleged victims of negligence at the hands of a previous clinician may decide to pursue a claim against them. In these circumstances you may be asked for a report in the expectation that it will support the patient's case. This can place dentists in a difficult position. You do, of course, have a duty of candour towards the patient, but you should avoid criticising the actions of other clinicians unnecessarily. You should simply disclose the records upon receipt of a written patient request. You should not provide a written report

regarding prior care, and you should avoid speculation.

Finally, there is the perennial risk that your corrective treatment will fail. Working from the time-honoured 'if you touched it you own it' principle, the patient may decide that you are liable for the entire problem. Obviously, you are liable for your own clinical standards. If errors have occurred at your hands, you must fulfil your duty of candour and aim to identify a practicable and equitable solution. However, bearing in mind the likely difficulties in trying to fix existing dentistry that is of a poor standard, the patient's decision to complain, though regrettable, may have been unavoidable. If so, any complaint can often be resisted if the records confirm that material risks were identified and explained before treatment commenced.

Conclusion

Most adults will receive dental treatment at some stage in their lives and the majority will be completed to an acceptable standard. Deficiencies can arise through wear and tear, possibly augmented by the patient's poor cooperation and a penchant for deep-fried Mars bars (other confectionary is available).

However, there will be occasions when all has not gone according to plan. Caries may have been missed. Root fillings may be short. Crowns may not fit. If a patient who has received this type of treatment attends your practice, the likelihood of disagreement and clinical complications is usually increased. Therefore, it is important to proceed with particular care. Communicate diplomatically yet with complete transparency regarding your findings. Do not be bounced into injudicious comment or treatment planning. If necessary, take time to reflect, talk to colleagues, seek second opinions and, of course, call an MDDUS adviser.

Doug Hamilton is a dental adviser at MDDUS and editor of SoundBite

BEYOND ORAL HEALTH

Professor Ruth Freeman talks about her innovative work in using oral health as a vehicle for social inclusion

A DENTAL professor in Scotland is changing the attitude, habits and capabilities of some of the UK's most vulnerable people through oral health.

Professor Ruth Freeman of the University of Dundee's School of Dentistry has been instrumental in developing successful schemes that have seen people in prison becoming oral health mentors.

Through the Scottish Oral Health Improvement Prison Programme (SOHIPP), Professor Freeman, along with researchers and partners across Scotland, has worked with people in custody to help them feel less socially excluded.

Improving oral health habits, Ruth says, can help rehabilitate them, improve their behaviour and ultimately encourage them to make positive lifestyle choices.

Social impact

SOHIPP aims to enable people actively to care for their own oral health, both inside and outside custody. It was launched following a 2011 survey of people in prison, carried out as part of the then Scottish Executive's Dental Action Plan. The survey found that the residents' dental health was poor, with a higher proportion of missing teeth compared to the general population.

Professor Freeman, whose work at the University's Dental Health Services Research Unit has a strong focus on tackling health inequalities, explains: "One thing that stuck in my mind about the survey results was the social impact of poor oral health.

"I remember one man asked: 'What lassie would want to kiss me with teeth like this?' People also told us they would talk upwind from people because of their bad breath; others found it difficult to eat or even speak.

"We asked them how we could solve their oral health problems, and they told us what they felt they needed."

Armed with this knowledge, Ruth joined forces with NHS Health Scotland and colleagues from NHS Boards to launch the national oral health initiative Mouth Matters in 2014. It was implemented by oral health promotion teams in the nine NHS Boards with prisons in Scotland - home to one of the highest per capita prison populations in Western Europe - and is still going strong five years on.

Coaching

A key part of the initiative was the introduction of oral health mentoring in prisons in NHS Forth Valley, followed by a ground-breaking peer health coaching programme in a high security prison.

People in Prison, Health Coaching for Scotland (PeP-SCOT) trains people in HMP Perth to become peer health coaches and is delivered in collaboration with NHS Tayside, the Scottish Prison Service (SPS) and the charity Positive Prison? Positive Futures (PPPF).

Following 92 hours of training, participants receive health coaching certification and qualifications and their skills have since been used to assist fellow prisoners to make positive lifestyle choices.

"As a result of PeP-SCOT we witnessed short and medium term changes in behaviour towards health, oral health, diet, exercise and smoking in the peer coaches and their clients," the Professor says.

She says her work now is "not just about oral health" and has become a means to improve other areas of people's lives such as smoking cessation, diet and exercise.

"The work that we are doing is about encouraging very small changes that could lead

to wider shifts in attitudes towards health," she says. "It's about working with people to maximise their capabilities and give them control of their lives."

She regards oral health as a "vehicle" to effect wider change. She says: "If you stop smoking, it's good for your oral health; if you change your diet and don't eat so much sugar, it's good for your oral health.

"They were also taught, by the prison, about drug awareness in the health coaching programme, so it went beyond oral health. We were really pleased about that - adopting the common risk factor approach."

Professor Freeman says she was struck by the enthusiasm of the peer-coaching students. "We saw people in the classroom working incredibly hard," she says. "The increase in their self-esteem was great to see, they were so proud to get their health coaching qualification, and their self-confidence grew immensely. That change was the thing that really hit me."

Now it has proved to be a success, Professor Freeman and the SOHIPP project team are hoping to attract more funding to develop it and are currently at the next stage of applying.

She says: "I am so pleased that we have amazing partners. I think because of partnership working it has been a success to date, but I still think we have a road to travel.

"What we want to do now is to get some funding to go back to the prison and conduct a feasibility study. We know it is working, but now we want to get the evidence, from that we can go ever onwards."

Engaging the homeless

Professor Freeman has also immersed herself in a separate programme addressing social inclusion issues affecting another key



"I have learned from people with experience of homelessness, people working in the NHS boards and people in prison"

vulnerable group – the homeless. The young person's project, run by her colleague at the University of Dundee's Dental School, Dr Andrea Rodriguez, ultimately aims to help young homeless people (or those at risk of experiencing homelessness) feel more included within society, but it begins with oral health education.

Ruth was inspired to take action after encountering homeless people and rough sleepers while working in London.

She says: "I did clinical work in King's Cross and when I walked around in the morning some young people who were sleeping rough would come up to me. They wanted money, but instead I would take them for a coffee and a bap – I still do that around Dundee. I remember meeting a couple on the Tube, and they looked so impoverished, my heart went out to them. I think it stemmed from that."

Now, there are oral health advocates across Scotland who work with homeless people in hostels and help them make dental appointments, often accompanying them to practices "because they feel so frightened and because of the stigma attached."

It is this team effort that Ruth believes is crucial. She says: "It's multi-disciplinary and multi-sectorial working – it's collaboration that works."

"I have learned from people – be it people with experience of homelessness, people working in the NHS boards and people in prison. They have helped us co-design and co-produce our interventions."

"We have used oral health to try and reduce social exclusion and inequalities and work with people. That has been a wonderful experience for me."

Kristin Ballantyne is a freelance writer based in Glasgow

After 12 months of neck stabbings and facial trauma, dentist **Kuljit Kaur** recalls how she managed the transition from maxillofacial surgery back to dentistry

CHANGING PACE

THE chaos of a year of maxillofacial surgery training (maxfac) is not to be underestimated. The constant ringing of the on-call phone. The endless hours. The never-ending flow of patients. However, for those who survive this test of endurance, returning to the world of dentistry can be even more disorientating and foreign.

As many dentists before me, I decided to take on the challenge of maxfac as a dental core trainee (DCT). During the course of the year I was involved in the treatment of neck stabbings, facial trauma and systemically unwell patients. In short: anything but teeth.

I quickly became immersed in the world of HbA1cs, haemoglobin levels and inflammatory markers, but the fear of not knowing what new challenge would come through the door was particularly daunting. Knowing that help was only a phone call away provided some reassurance.

While the four-hour A&E rule may to the average person sound plentiful, it's surprising how restricting it becomes when you receive multiple referrals in quick succession. Seeing in the New Year on-call was particularly exhausting, as non-stop alcohol-infused social events produced a surge in patients. Maxfac teaches you to see the bigger picture in life, prioritising the medical management of septic patients. Most importantly, it reminds dentists that teeth aren't everything.

So how does one readjust from this high-pressure, fast-paced environment to picking up a handpiece again? The answer is... with great difficulty.

Switching from maxfac trainee to my next role as a restorative trainee wasn't easy. But I learned that, while rehabilitating tooth wear cases may not offer the same immediate gratification of stabilising an exsanguinating patient, you still have a valuable part to play in that patient's care.

For the first few days, the contrast with maxfac was stark. No more waiting for the ringing of the on-call phone. No unexpected attendances of systemically unwell patients. In their place was a structured diary with clearly outlined treatment plans. The urgent bleeping of emergency resuscitation room monitors was replaced by the gentle bleeping of the apex locator.

My first month of restorative dentistry was the steepest learning curve as I tried to get a grasp on Ackerly's classifications and implant components while fumbling my way around a denar facebow. I realised I had (not for the first time) shifted from being unconsciously competent to unconsciously incompetent in a matter of days. As Broadwell's theory of learning goes, in the beginning you lack the skill but don't realise it (unconsciously incompetent). Next, you develop competence that requires conscious effort, but eventually it becomes second nature (unconsciously competent). It was with this comforting thought that I pushed on, appreciating that learning new skills and revisiting old skills would take time and effort.

Now several months down the line, I can ably demonstrate to junior colleagues how to obtain a facebow registration. What was once a complex contraption is now a useful adjunct to replicating jaw movements. Although it has been a steep learning curve it's been enriching to appreciate the individual complexities within restorative dentistry, from apexectomies to obturators.

For those transitioning to different fields in the hospital sector, the change can be significant. I've noted these four useful steps to progressing:

1. Accepting you have deskilled in some areas

You realise that in the process of acquiring new skills you have become deskilled in some basic areas of dentistry. Simply accessing a tooth again

may feel odd as you think over the complex anatomy of dental pulps. But don't forget that your confidence will return with time and experience. We can't be expected to know the intricacies of every specialty.

2. Seeking advice and guidance

Asking for help from senior colleagues is crucial, especially in the first few months. Simply revisiting the basic principles of dentistry will jog a rusty memory. You may realise you are missing some specifics, but the main concepts should still be imprinted in your memory. Accept that saying "I'm not sure" isn't a failure, but a learning opportunity to be explored.

3. Creating opportunities

"You reap what you sow" is a common saying but very true. As with any change of job, the environment is different and it's often difficult to determine what your role is in that team when multiple levels of hierarchy are present. However, being well prepared and arriving on time gives the best chance to find your place and offer assistance. Be proactive and ask for cases that are of interest to you - the best learning opportunities can appear when you're outside your comfort zone.

4. Learning from mistakes

Oscar Wilde famously said: "Experience is simply the name we gave our mistakes". None of us wish to make mistakes or errors knowingly; but this can hold us back from pushing ourselves to progress. Mistakes will happen but it is how you grow and develop from them that determine success in the long run.

Kuljit Kaur is a dentist based in Newcastle



GIVING VOICE

As the #metoo movement continues to make headlines, **Janice Sibbald** offers advice on tackling inappropriate behaviour at work

HE IS the brains behind some of Hollywood's biggest movies, but Harvey Weinstein stands accused of a catalogue of claims of sexual harassment against actresses and female employees spanning the last two decades.

A renowned film producer, Weinstein allegedly used his position of authority and power to sexually harass women. Not long after these accusations emerged, the "#MeToo" movement spread virally across social media encouraging women to speak out about their own experiences of inappropriate behaviour.

It is clear that sexual harassment is very much an issue in many workplaces. Two in five women in the UK say they have experienced unwanted sexual behaviour at work but only a quarter reported it, according to a BBC survey. The issue does not only impact women, with 18 per cent of men stating that they too have been harassed at work.

What is it?

Sexual harassment is unwanted behaviour of a sexual nature that:

- violates your dignity
- makes you feel intimidated, degraded or humiliated
- creates a hostile or offensive environment.

It can be broadly categorised into three groups: verbal, non-verbal and physical. It can happen to women and men and can occur between people of the same sex or the opposite sex.

Examples of verbal harassment include comments about appearance, body or clothes; indecent remarks; and questions or comments about your sex life. Non-verbal harassment may involve looking or staring at a person's body; displaying sexually explicit material such as photos or magazines; or sharing emails with

sexual content. Physical harassment can range from physically touching, pinching, hugging or kissing to assault and rape. Harassment can be subtle and you don't have to have previously objected to someone's behaviour for it to be unwanted. Even if the person didn't mean for it to be perceived that way, it can still very much be classed as harassment. We frequently get calls from practices about "banter" in the workplace. After all, it is just a bit of harmless fun isn't it? Bear in mind that what one person may deem as "joking around" or light-hearted fun might be perceived by another as sexually inappropriate.

Case law

The employment tribunal cases described below provide useful learning points to any employer tempted to dismiss or fail to take seriously complaints of harassment from employees.

In the case of *Austin v Samuel Grant (North East) Ltd*, a heterosexual male employee won a harassment claim on the basis of sexual orientation and religion or belief. The employee was referred to as "homosexual" and "gay" by colleagues because he had told them that he didn't like football. He had filed a grievance but the HR director rejected it on the basis that the remarks were simply "office banter".

In *Furlong v BMC Software Ltd*, a tribunal upheld an employee's claim that she was subjected to sex discrimination and sexual harassment, including an incident where a senior manager groped her bottom and told her "he would like to eat her like a marshmallow". As well as upholding the employee's claim, the tribunal made recommendations to the employer to review their equal opportunities policy and training to management.

Harassment of a sexual nature is one of the most common forms of harassment and is specifically outlawed by the Equality Act 2010.

Taking action

Employers can prevent or address this issue by having an up-to-date and relevant policy that you may wish to display in the workplace. It should include:

- a statement of commitment from senior management
- a clear statement that bullying/harassment is unlawful and will not be tolerated
- examples of unacceptable behaviour and a statement that bullying and harassment may be treated as disciplinary offences
- reference to confidential routes for complaints and protection from victimisation
- how the policy is to be implemented, reviewed and monitored.

The important thing is to ensure that employees are aware of how they can raise concerns and that they feel supported in doing so. Complaints should always be taken seriously and handled fairly and sensitively. Some organisations suggest complaints are made in writing in the form of a grievance letter to the relevant supervisor (likely to be the practice manager). It may be helpful for the complainant to make notes about the incident in question, especially if recalling the incident is particularly upsetting. Remember to also offer support and sensitivity to the person accused of harassment as this can be a distressing experience for them too.

This is a sensitive and complex area of employee relations and if you need any support or advice please contact an MDDUS employment law adviser. There is also useful information on the Acas website.

Janice Sibbald is an employment law adviser at MDDUS

TREATMENT

Substandard RCT alleged

DAY ONE

Mr P, 52, attends his dentist, Dr N, with pain in the upper right quadrant. Clinical and radiographic examinations reveal tenderness to percussion and widening of the periodontal ligament space (indicating formation of an abscess) associated with UR8. Dr N diagnoses irreversible pulpitis and suggests root canal treatment (RCT) or extraction. Mr P is further advised that the root canals of UR8 look sclerosed on the radiographs and may be difficult to locate. Dr N explains that the success rate for RCT is around 80 per cent. The patient agrees to the procedure as UR8 is the only standing molar and retains Mr P's partial upper denture.



WEEK FIVE

Mr P attends the surgery for the first stage of RCT to UR8, which is carried out using rubber dam and rotary instruments and is irrigated with sodium hypochlorite. Dr N has difficulty locating one of the root canals and asks for help from a colleague. It is eventually located and the rest of the treatment is carried out as planned. The tooth is temporarily restored and Mr P is advised of possible post-operative soreness over the next few days and is asked to contact the practice if the discomfort does not resolve.



WEEK EIGHT

Mr P returns to the surgery complaining of pain associated with UR8 and also UR2. Clinical examination reveals tenderness to pressure on UR8 but no occlusal disharmony (i.e. disturbance to his bite) and Dr N advises the patient that the tooth should settle given time. UR2 is found to be tender with palatal pressure but there are no other clinical signs. Dr N suggests two possible causes for the pain: a recurrent infection due to a failing root filling (present for 15 years although with no previous problems) or a root fracture. The dentist advises that in either case the prognosis for the tooth is poor. A radiograph is taken but there is no obvious root fracture - just evidence of a badly aligned post and early abscess formation around the root. This is the last time Mr P attends the practice.



WEEK SIX

Dr N completes the RCT treatment using a local anaesthetic under rubber dam. A post-operative radiograph is taken and this shows a good quality root filling present. Mr P had reported some tenderness over UR8 for the previous few days and is again advised of possible post-operative tenderness and told to contact the practice if the symptoms persist.

A LETTER of claim is sent to Dr N alleging clinical negligence in his treatment of Mr P. It claims that Dr N failed to clean/ fill the patient's root canals at UR8 to an appropriate standard and had to ask for help during the treatment. It is also alleged that Dr N put pressure on UR2 while undertaking the second part of RCT on UR8, causing a root fracture which he later failed to diagnose.

MDDUS instructs an endodontic specialist to provide an expert opinion. Subsequent disclosure of the full dental records reveals that Mr P attended a different dentist after the treatment by Dr N. This dentist advised the patient that the RCT of UR8 was substandard and the procedure was redone - and it is further claimed that the previous gutta percha (GP) root fillings were easily removed with tweezers.

The endodontic specialist examines Dr N's treatment records which record in detail the treatment plan and consent discussions with the patient. The post-RCT radiograph taken by Dr N shows well-condensed root fillings present and the expert questions the second dentist's claim that they could be removed by tweezers.

The expert states that in carrying out the RCT over two appointments Dr N was following best practice. Requesting assistance from a colleague does not suggest the treatment fell below a reasonable standard of care and it is noted that Mr P was warned that the root canals looked sclerosed and might prove troublesome.

The expert also reasons that it would be highly unlikely that Dr N exerted pressure on

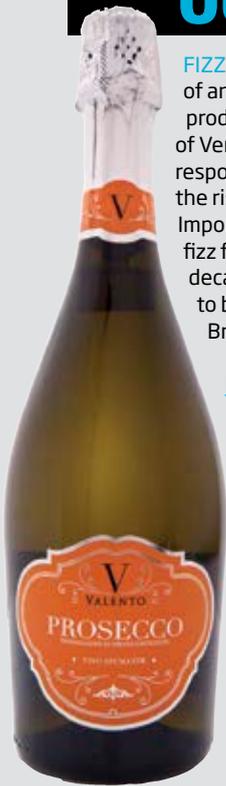
UR2 whilst carrying out RCT on UR8, given the dentist is left-handed and would not have used UR2 as a stabilising point. The radiograph taken by Dr N of UR2 shows no sign of a root fracture but rather evidence of abscess formation, which was the likely cause of the pain.

MDDUS sends a letter of response denying negligence and nothing further is heard from Mr P's solicitors. The case is eventually closed on expiry of the legal limitation period.

KEY POINTS

- Good record keeping is invaluable in defending against negligence claims.
- Ensure patients understand what can be reasonably expected from treatment.

OUT THERE



FIZZ FURY British dentists stand accused of an “Anglo-Saxon crusade against Italian products”. These are the angry words of Veneto regional governor Luca Zaia in response to recent public health warnings of the risks of drinking acidic, sugary prosecco. Imports to the UK of the popular Italian fizz fell by seven per cent this year after a decade of growth - and farmers are said to be blaming dental chiefs (along with a Brexit-enfeebléd pound).

JAM IN A JAM Sticking with the theme of sugar shaming, it seems Public Health England (PHE) bears some blame for the drop in popularity of jam. Sales in Britain fell by 2.9 per cent in 2017, down to £106 million. This follows PHE’s drive to reduce children’s sugar consumption by 20 per cent by 2020. Jam contains a whopping 10g of sugar per tablespoon. Ironically, sales of marmalade (which contains 12g of sugar per tbsp) surged three per cent thanks to the popularity of the film *Paddington 2*.



FROM THE MUSEUM

In 1924, UK-born chemist Otto Overbeck patented “The Rejuvenator”. He linked many ailments, including toothache, to an electrical imbalance. He claimed passing electricity through “diseased” parts of the body would “cure” the patient and extend life. His machine produced no benefits whatsoever but it did make him wealthy.

PHOTOGRAPH: BDA MUSEUM

CROSSWORD

ACROSS

1. Dentists’ clinical responsibility, _____ of care (4)
3. Ease symptoms without curing cause (8)
9. Collection of pus caused by bacterial infection (7)
10. Uses teeth to pierce surface (5)
11. UFO of 1950s vintage? (6,6)
13. Split between factions (6)
15. Ornamental dwarfed tree (6)
17. Device used by Police to detect alcohol (12)
20. See 23
21. Move forward (7)
22. Stand in for (8)
23. (and 20) Actor who used dental prostheses to portray Freddie Mercury (4, 5)

DOWN

1. Restricted growth (8)
2. Delicious (5)
4. Consider (6)
5. Task done for pleasure, not reward (6,2,4)
6. Branched horns of deer (7)
7. Unchallenging (4)
8. Tool of Andy Murray’s trade (6,6)
12. Prime Minister, 1868 and 1874-1880 (8)
14. Archaic name for orofacial cleft (4-3)
16. Secateurs (6)
18. Natural laxative (5)
19. Surrounded by (4)

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See answers online at www.mddus.com. Go to the Notice Board page under About us.

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For more information and/or to book a place, please contact Ann Fitzpatrick, Administrator on **0333 043 4444** or email risk@mddus.com



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