SENATE OF DENTAL SPECIALTIES

GOOD PRACTICE IN THE DENTAL SPECIALTIES

Good Practice in the Dental Specialties

November 2001

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The Senate of Dental Specialties

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Aims and Objectives

To promote the highest standards of professional practice in the dental specialties by providing a forum for communication between the Dental Faculties of the Surgical Royal Colleges and the Specialist Associations in dentistry

To develop a framework and a culture within which all dental specialists can demonstrate that they are keeping themselves up to date and remain fit to practise within their chosen field.

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under 'Documents and Publications'.
The Personal Professional Portfolio is also available to download in PDF format.

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Foreword

It is a great pleasure to introduce
Good Practice in the Dental Specialties
which builds upon *Quality Assurance in the Dental Specialties*
published in 2000.

The Senate of Dental Specialties hopes that all dental specialists, together with those with an interest in specialist dental practice, will find this new publication of interest and of help in working towards our common aim to achieve the highest quality of care for patients.

David Barnard CBE

Chairman
Senate of Dental Specialties

November 2001

Introduction

Good Practice in the Dental Specialties aims to set standards for dental specialists to provide the highest quality of care for patients.

In the preparation of *Good Practice in the Dental Specialties*, the Senate of Dental Specialties has taken into account existing guidance for standards of practice:

• *Maintaining Standards*	General Dental Council
• *Good Medical Practice*	General Medical Council
• *Good Surgical Practice*	The Royal College of Surgeons of England
• *The Surgeon's Duty of Care*	The Senate of Surgery of Great Britain and Ireland
• *Consultant Surgeons – Teamworking in Surgical Practice*	The Senate of Surgery of Great Britain and Ireland

Whilst the guidance contained in *Maintaining Standards* is fundamental for registered dentists, the Senate of Dental Specialties supports the principle that standards for dental specialists should parallel those put in place for the medical specialties.

Good Practice in the Dental Specialties offers generic guidance for all specialists together with specialty specific guidance against which performance can be assessed. Where appropriate additional references are provided in each section.

Specialists employed as Consultants in the National Health Service have a contractual requirement for annual appraisal in accordance with *Advance Letter* (MD) 06/00, 05/01. For other specialists a Personal Professional Portfolio has been developed which includes a section entitled Practice Profiles. All specialists are recommended to maintain a Personal Professional Portfolio as proposed in *Quality Assurance for the Dental Specialties,* Senate of Dental Specialties, 2000. This will provide documentary evidence of good practice for the individual specialist and the practising environment.

Whilst *Good Practice in the Dental Specialties* recognises and follows the principles outlined in the documents listed above, it *is not* intended to supersede them.

Each heading in this document is followed by a shaded section in italics which is taken from the relevant section of the appropriate existing guidance for standards of practice. Each is followed by guidance on how the standards of care may be practically achieved.

Part 1

Quality of Clinical Practice

Clinical Care

> *A patient is entitled to expect that a dentist will provide a high standard of care.*
>
> General Dental Council, *Maintaining Standards*, paragraph 3.2

For dental specialists, good clinical care includes:

- putting the interests of the patient first
- providing a high standard of care
- not discriminating between patients except on clinical grounds
- making an adequate assessment of the patient's condition, based on the history and clinical signs
- providing or arranging appropriate investigations
- using judgement in taking suitable and prompt action when necessary
- ensuring that clinical techniques are carried out competently
- communicating compassionately with patients and their relatives
- ensuring the maintenance of clear and accurate records
- ensuring patients are cared for in an appropriate environment
- ensuring patients receive adequate post treatment care and that relevant information is promptly and effectively communicated to patients and to those responsible for their on-going care
- only accepting patients on specialist referral from general dental or medical practitioners, consultant colleagues or as an emergency through the accident and emergency department. If a patient is accepted directly, the patient should be informed that the general practitioner will normally receive a report[1]
- ensuring that, on the discharge of a patient from specialist care, appropriate information and a management plan are sent to the patient's general practitioner
- utilising the knowledge and skills of other clinicians when appropriate
- transferring the patient, when necessary, to another unit or colleague where the appropriate resources and skills are available.

[1] Note: Specialist lists held by the GDC are indicative, not restrictive. This means that holders of prescribed specialist titles remain free to practise across the whole spectrum of dentistry within their acknowledged competence, General Dental Council, *Maintaining Standards*, paragraph 1.5

Keeping Up-to-date

> *In the interests of patients, a dentist has a duty to continue professional education whilst continuing to practise. A dentist who fails to maintain and update professional knowledge and skills and who, as a result, provides treatment which falls short of the standards which the public and the profession have a right to expect, may be liable to a charge of serious professional misconduct.*
>
> GENERAL DENTAL COUNCIL *Maintaining Standards*, paragraph 1.3

PERSONAL DEVELOPMENT AND CONTINUING PROFESSIONAL EDUCATION

All specialists must continue to develop relevant clinical and academic skills.
This can be achieved by, for example:

- regular clinical discussion with colleagues
- reading the relevant specialist literature and accessing information from academic sources
- attending meetings and courses which may be
  - within the work place
  - external - regional, national or international.

Specialists should participate in the development of outcome measures for clinical procedures and must take part in audit.

Specialists should take every opportunity to expose their practice to peer review, and to further develop their skills. This can be achieved through:

- multi-disciplinary meetings
- regional specialty meetings
- being visited by a specialist colleague
- visiting another specialist
- multimedia information
- visiting an expert
- attending a skills course
- participation in appropriate quality assurance schemes.

Many of these activities should be part of a personal development plan and should be detailed in appraisal documentation or the Personal Professional Portfolio.

All specialists should record their continuing professional development activity and register with one of the following:

- Continuing Professional Education for the dental specialist scheme of the Dental Faculties and Specialist Associations
- Continuing Medical Education for the trained surgeon scheme of the Senate of Surgery of Great Britain and Ireland
- another Royal College scheme appropriate to the specialty.

Those specialists for whom continuing professional development will not be mandatory for continuing registration with the General Dental Council from 1st January 2002, should join the General Dental Council preparatory scheme, *Life Long Learning* : *Recertification for the Dental Profession*. This has reciprocity for data collection provided that the format is matched with the proforma that can be accessed on the Council's website at www.gds-uk.org

NEW TECHNIQUES

> *Any surgeon undertaking a new surgical procedure or significant variation on current practice must accept special obligations to the patients involved. The balance between possible benefits and any conceivable risks must be fully explained to the patient. If a technique is considered by the profession to be sufficiently novel as to require special training and assessment before being introduced into general clinical practice, its initial use should be regulated and limited to a number of specified centres for clinical trial.*
>
> *A mechanism for assessing new interventional procedures was established by the Academy of Medical Royal Colleges: The Safety and Efficiency Register of New Interventional Procedures (SERNIP)*
>
> The Senate of Surgery of Great Britain and Ireland *The Surgeon's Duty of Care,* page 21

In learning or developing new techniques, the interests of patients are predominant.

When a new technique is to be undertaken, initially it may involve personal supervision by an expert. Clinical and academic innovation is positively encouraged.

When a new technique is to be developed:

- discuss it with colleagues at the outset
- obtain ethical approval as required
- ensure fully valid consent is obtained from patients
- review progress with a peer group
- give details in appraisal documentation or the Personal Professional Portfolio.

Accepting a Referral

> *It is the responsibility of a dentist when accepting a referral to ensure that the request is fully understood. The treatment or advice requested should only be provided where this is felt to be appropriate. If this is not the case, there is an obligation on the dentist to discuss the matter, prior to commencing treatment, with the referring practitioner and the patient.*
>
> General Dental Council, *Maintaining Standards*, paragraph 3.4

Referrals are usually from other specialist colleagues, general dental or medical practitioners. Clear and prompt communication is required.

When invited to give an opinion or to assist in the management of a patient, specialists should do so promptly and communicate their opinion and advice to the referring colleague.

Referring practitioners should be encouraged to enclose relevant radiographs to minimise exposure.

Making a Referral

> *When accepting a patient a dentist assumes a duty of care which includes the obligation to refer the patient for further professional advice or treatment if it transpires that the task in hand is beyond the dentist's own skills. A patient is entitled to a referral for a second opinion at any time and the dentist is under an obligation to accede to the request and to do so promptly.*
>
> General Dental Council, *Maintaining Standards*, paragraph 3.3

Patients are entitled to the highest standards of care possible and, wherever treatment is beyond the professional scope of the specialist, it is the responsibility of that specialist to refer the patient for further professional care.

Requests for a second opinion should always be honoured without prejudice to the patient.

Referral for a specialist opinion should always be made in a manner which preserves patient confidentiality and complies with the provisions of the Data Protection Act.

Where the referring practitioner has reason to believe that the patient requires emergency treatment or urgent diagnosis this should be made clear in the correspondence and supplemented by personal contact with the specialist concerned.

REFERRING A PATIENT FOR TREATMENT UNDER GENERAL ANAESTHESIA

The specialist accepting a referral for treatment under sedation or general anaesthesia is responsible for deciding the most appropriate form of pain and anxiety control in consultation with the patient.

If a patient is to be referred, then:

- an appropriate medical history should be taken
- an explanation of the risks involved in general anaesthesia should be given to the patient and alternative methods of pain control available should be discussed
- the patient should be referred only if the patient has agreed to this

The referral letter must contain:

- clear justification for the use of general anaesthesia
- details of the relevant medical and dental histories of the patient

The referring specialist must retain a copy of this letter.

Specialists must take into consideration new regulations which require that, by 31 December 2001, all general anaesthesia for dental treatment should be administered in a hospital setting with critical care facilities.

The National Health Service (General Dental Services) Amendment Regulation, 2001

A Conscious Decision. A Review of the Use of General Anaesthesia and Conscious Sedation in Primary Dental Care, Department of Health, July 2000
www.doh.gov.uk/dental/conscious.htm

Consent

> *A dentist must explain to the patient the treatment proposed, the risks involved and alternative treatments and ensure that appropriate consent is obtained.*
>
> GENERAL DENTAL COUNCIL, *Maintaining Standards*, paragraph 3.7

The specialist should take care to describe treatment options clearly and comprehensively and in terminology easily understood by the patient. This particularly applies to children and in addition should take into account that English may not be the patient's first language.

The specialist should discuss all relevant treatment possibilities (including non-treatment) and expected outcomes with the patient. In relation to children and those with learning disabilities great care should be taken also to communicate effectively with parents and carers.

Decisions about treatment options should be joint decisions made between specialist and patient.

It is the responsibility of the specialist to ensure that appropriate consent is obtained. The use of written explanations is encouraged.

It is the responsibility of the specialist to:

- explain all viable treatment options to the patient
- ensure that all necessary information and explanations are given either personally or by appropriately trained colleagues to whom this responsibility has been delegated
- obtain written consent from the patient if a decision to carry out treatment under general anaesthesia or sedation has been agreed
- explain material risks that may be involved in treatment
- discuss the cost if this is applicable.

It should be considered good practice to obtain written consent both for surgical procedures and any other advanced forms of treatment under local anaesthesia.

The signing of a consent form by the patient should not become an end in itself, and is never a substitute for proper two-way communication.

PATIENTS WITH SPECIAL NEEDS

Where it is considered that a patient is unable to understand and, therefore, give valid consent, the specialist should discuss the matter with those in charge of the patient's medical care in addition to the carer. In the United Kingdom, no adult, including next-of-kin, can give consent on behalf of another adult (aged 18 or over). Different arrangements apply in Scotland. As the law currently stands a patient who lacks the capacity to consent may be treated without consent providing the treatment is necessary and in the patient's best interests. Even where the views of people who are close to the patient have no legal status in terms of actual decision making it is good practice for the health care team to consult with them, in assessing the patient's best interests. This also may be a requirement of the Human Rights Act. Any such enquiries should however be mindful of the duty of confidentiality owed to the patient.

When general anaesthesia is involved a joint declaration must be agreed with the carers and signed on behalf of the patient by two clinicians.

In an emergency situation, the specialist should proceed with treatment in the patient's best interest.
Integrated Care Pathways of Oral Care for People with Learning Disabilities, Faculty of Dental Surgery, The Royal College of Surgeons of England and the British Society for Disability and Oral Health, 2001
www.rcseng.ac.uk/fds/documents

Putting Rights into Public Service. The Human Rights Act 1998. An Introduction for Public Authorities, The Home Office, July 1999

CHILDREN AND YOUNG PEOPLE

Consent must also be sought before examining, treating or caring for a child. Young people aged 16 years of age and over are presumed to have the competence to give consent for themselves. Younger children who fully understand what is involved in the proposed procedure can also give consent (although their parents will ideally be involved). In other cases agreement must be obtained, on the child's behalf, from someone with parental responsibility, unless it is an emergency and they cannot be contacted. If a competent child consents to treatment, a parent **cannot** over-ride that consent. Legally a parent can agree to treatment if a competent child refuses but it is likely that taking such a serious step will be rare.

Information and Consent for Anaesthesia, Association of Anaesthetists of Great Britain and Ireland, July 1999
www.aagbi.org

Report of the Consent Working Party Incorporating Consent Toolkit, British Medical Association, 2001
www.bma.org.uk

Reference Guide to Consent for Examination or Treatment, Department of Health, 2001
www.doh.gov.uk/consent

The Children Act, Her Majesty's Stationery Office, 1989

Consent to treatment is an evolving area, and it is therefore important to keep up to date with developments.

Providing for Emergencies and Out of Hours Care

> *A dentist working in any branch of dentistry must make appropriate arrangements to ensure that patients, for whom responsibility has been accepted, have access to emergency treatment outside normal working hours and that such arrangements are made known to those patients.*
>
> GENERAL DENTAL COUNCIL, *Maintaining Standards,* paragraph 3.11

Patients should be given clear and comprehensive pre and post-operative instructions in writing.

Patients should be given information as to where they might receive post treatment care in case of an emergency.

It is the specialist's duty to provide, or make arrangements for the patient to receive advice or treatment as soon as possible.

Following treatment, all patients must be assessed for their suitability for discharge. Patients and escorts must be given specific post-operative advice regarding individual after care arrangements.

Patients who have received conscious sedation or who are recovering from general anaesthesia must be appropriately protected and monitored in adequate and supervised recovery facilities. When sufficiently recovered to leave the premises, in the opinion of the member of the care team responsible, the patient should be discharged into the care of an accompanying adult. Delegation of the discharge responsibility should be informed by an agreed written protocol.

Infection Control

> *A dentist has a duty to take appropriate precautions to protect patients and other members of the dental team from [the] risk [of cross-infection].*
>
> GENERAL DENTAL COUNCIL, *Maintaining Standards*, paragraph 4.1

- Every patient is a potential infection control risk. Appropriate universal precautions should be implemented for all patients
- For detailed guidance on infection control see the relevant documents issued by the health departments and the British Dental Association
- It is unethical for a specialist to refuse to treat a patient solely on the grounds that the person has a serious communicable disease (see also Acting in the Best Interests of Patients, page 20)
- All specialists have a duty to seek advice from an appropriately qualified doctor if they believe they have a communicable disease which may jeopardise the wellbeing of patients

- If found to be affected by a serious transmissible disease the specialist should seek expert advice regarding any need to modify working practices
- Specialists also have the duty to inform the appropriate authority if they believe a colleague may have a serious communicable disease which may put patients at risk
- It is the responsibility of the specialist to keep up to date and abide by any legislation governing the disposal of clinical and hazardous waste
- All specialists have a responsibility to keep up to date their vaccination status related to appropriate infectious diseases.

Pain and Anxiety Control

Dentists have a duty to provide and patients have a right to expect adequate and appropriate pain and anxiety control.

GENERAL DENTAL COUNCIL, *Maintaining Standards*, paragraph 4.8

There can be no justification for intimidation or, other than in the most exceptional circumstances, for the use of physical restraint in dealing with a difficult patient.

GENERAL DENTAL COUNCIL, *Maintaining Standards*, paragraph 3.10

Treatment plans for patients whose anxiety makes them unable to co-operate should take into account the need to reduce that anxiety to enable treatment to proceed. Imposing treatment contravenes *The Human Rights Act*, 1998, Article 3.

The specialist should consider all aspects of behavioural management before deciding to prescribe or proceed with treatment.

Pharmacological methods of pain and anxiety control include local anaesthesia, conscious sedation and general anaesthesia.

When selecting any form of pain or anxiety control the specialist should:

- consider the patient's medical and dental history
- use the most appropriate and effective management for the individual patient
- pay due consideration to the physical and pharmacological effects of any agent used
- select the most suitable procedure involving minimum intervention in consultation with the patient and when appropriate, their carer.

Conscious Sedation

Conscious sedation can be an effective method of facilitating dental treatment and is normally used in conjunction with appropriate local anaesthesia.

GENERAL DENTAL COUNCIL, *Maintaining Standards*, paragraph 4.11

Dentists have a duty to administer sedation only within the limits of their knowledge, training, skills and experience.

GENERAL DENTAL COUNCIL, *Maintaining Standards*, paragraph 4.14

Any specialist carrying out treatment of a patient under conscious sedation must have the relevant postgraduate education and training as well as a commitment to updating and continuing that training.

All staff in the team must be trained in the use of conscious sedation techniques and the remedial action required should complications occur.

Before deciding to treat a patient under conscious sedation:

- A relevant medical and dental history must be taken
- A clear treatment plan should be agreed with the patient
- The specialist should clearly and comprehensively explain the sedation technique to the patient
- Alternative methods of pain and anxiety control should be explained to the patient
- Written consent should be obtained from the patient (see also Consent, page 12)
- The patient and their carer should be given clear pre and post-operative verbal and written instructions, ensuring that communication is understood.

During treatment under conscious sedation:

- The level of sedation must be such that the patient remains conscious, the nature and dosage of drugs should be kept to the minimum necessary to achieve the desired effect
- Verbal contact with the patient must be maintained throughout the period of sedation
- The specialist should ensure that the patient is able to understand and respond to verbal commands and that the patient retains protective reflexes
- The specialist should be assisted by an appropriately trained person who is able to monitor the condition of the patient and assist in case of emergency
- Adequate facilities including appropriate drugs should be readily available in the event of complications arising.

It is the responsibility of the specialist administering the sedation to keep comprehensive records of the conscious sedation technique and drugs used (*Standards in Conscious Sedation for Dentistry,* Report of an Independent Expert Working Party, October 2000).

General Anaesthesia

> *[A dentist should ensure] due regard is given to all aspects of behavioural management and anxiety control before deciding to prescribe or proceed with treatment under general anaesthesia*
>
> GENERAL DENTAL COUNCIL, *Maintaining Standards*, paragraph 4.17

Specialists must take into consideration new regulations which require that, by 31 December 2001, all general anaesthesia for dental treatment should be administered in a hospital setting with critical care facilities (*General Anaesthesia for Dental Treatment in a Hospital Setting with Critical Care Facilities*, Chief Dental Officer, 31 May 2001)

All staff in the team contributing to treatment under general anaesthesia must be trained in resuscitation and life-support.

Before deciding to treat a patient under general anaesthesia:

- A relevant medical and dental history must be taken
- A clear treatment plan should be agreed with the patient
- Alternative methods of pain and anxiety control should be explained to the patient
- Written consent should be obtained from the patient (see also Consent, page 12)
- The patient and, if appropriate, their carer should be given clear pre and post operative verbal and written instructions. Care should be taken to ensure that these have been understood.

Records

> *A dentist must always obtain a medical history of a patient before commencing treatment and check the history for any changes at subsequent visits. Changes must be recorded in the patient's notes.*
> *Full contemporaneous records should be kept for all dental treatment.*
>
> GENERAL DENTAL COUNCIL, *Maintaining Standards*, paragraph 4.3

Records should include:

- the patient's details
- the date of each entry
- copies of any communication relating to the patient

- the medical history of the patient (this should be recorded before commencing treatment and should be updated upon each visit following consultation with the patient)
- contemporaneous records of any conscious sedation technique used and any drugs administered
- copies of written consent obtained (where appropriate)
- full details of all procedures undertaken and the outcome
- the countersignature of the interpreter (where relevant)
- unwanted potential effects of treatment must be discussed with the patient and the details recorded
- clinical data retained in training or Portfolio logbooks should be anonymised or password protected whether in hard copy or electronic format.

Patient records, including photographs, radiographs and other imaging records, ECG, relevant study models, histopathological specimens, other special investigations and reports should be retained where possible.

The dentist/patient relationship is founded on trust. A dentist should not disclose to a third party information about a patient acquired in a professional capacity without the permission of the patient (see Maintaining Confidentiality, page 21).

Dental Radiography and Radiation Protection

A dentist has a number of statutory duties in relation to radiation protection during dental radiography.

A dentist who delegates the taking of dental radiographs must ensure that the person to whom this task is delegated has received training in accordance with the Regulations.

General Dental Council, *Maintaining Standards*, paragraph 4.4

It is the responsibility of the specialist to:

- comply with the *Ionising Radiations Regulation*, 1999 and the *Ionising Radiation (Medical Exposure) Regulations* (IRMER), 2000
- act, where appropriate as the legal person (employer), and take responsibility for implementing the above regulations
- act, where appropriate as an employee, in accordance with the employer's procedures, protocols and local rules
- provide sufficient clinical information to enable the IRMER practitioner to decide whether the exposure is justified, in accordance with agreed referral criteria
- be adequately trained when acting as an IRMER practitioner (to justify the exposure) or an IRMER operator (to optimise the radiation exposure)
- ensure the safety of patients, members of staff and the public
- ensure that radiographic equipment is operated in compliance with current legislation and guidelines

Part 2

Ethical and Professional Relationships with Patients

Probity

> *A dentist must adhere to the appropriate standards of personal as well as professional conduct.*
>
> General Dental Council, *Maintaining Standards*, paragraph 2.1

A specialist must not receive fees for which there is no entitlement or persuade a patient to accept private treatment by giving incorrect information.

All specialists must:

- fulfil NHS contracted duties
- not use NHS staff or resources to aid their private practice unless specific arrangements have been agreed to do so
- make arrangements for the continuity of care
- properly record and audit specialist activity
- if working solely in private practice, foster peer review and participate in audit and continuing professional development
- be honest in financial and commercial matters relating to work. In particular, all specialists must:
  - ensure that patients are fully aware of the financial costs of treatment
  - inform patients if part of the fee goes to another professional
  - not defraud patients, the service, the organisation worked for, or any third party involved in the settlement of accounts, e.g. insurance companies
  - not allow commercial incentives to influence treatment given to a patient
  - make clear the limits of care available in private practice.

Communication

Communication with patients, whether adult, child or a person with learning disabilities, is central to good clinical practice. This involves listening to patients, respecting their views and treating them politely and considerately.

Communication begins in the specialist clinic where relationships are established and the first communications are made. Clinicians need to be sensitive to the varying needs of patients and their desire for either detailed or less detailed explanations.

Quality of care may demand unhurried discussion; valid consent must be obtained.

Where appropriate verbal communication should be supported by written information.

Plans, procedures, risks and expectations need to be communicated and documented in the patient's notes.

If problems arise, full explanations must be given. Mistakes must be openly acknowledged. When appropriate, apologies must also be given.

A patient has a right to expect that a specialist will achieve the highest possible quality of patient care.

Awareness and understanding of differing cultural sensitivities is necessary.

If a patient requests a second opinion, this should be supported and assistance given in arranging this wherever possible.

Professional Responsibility Towards Protecting Patients

A dentist must act to protect patients when there is reason to believe that they are threatened by a colleague's conduct, performance or health. The safety of patients must come first at all times and should over-ride personal and professional loyalties.

GENERAL DENTAL COUNCIL, *Maintaining Standards*, paragraph 2.4

Working with colleagues brings responsibility. If a colleague is perceived to have a problem with clinical procedures, behaviour or health then it is the specialist's responsibility to protect patients and to help in the resolution of the problem. The concerned clinician should try to verify the facts and then discuss the matter with an experienced colleague before taking action.

If a specialist becomes aware of any situation which puts a patient at risk, the matter should immediately be discussed with a senior colleague. It remains the responsibility of the specialist to ensure appropriate action has been taken.

Acting in the Best Interests of Patients

As a member of a caring profession, a dentist has the responsibility to put the interests of patients first. The professional relationship between dentist and patient relies on trust and the assumption that a dentist will act in the best interests of the patient.

GENERAL DENTAL COUNCIL, *Maintaining Standards*, paragraph 3.1

It is unethical for a dentist to refuse to treat a patient solely on the grounds that the person has a blood borne virus or any other transmissible disease or infection.

GENERAL DENTAL COUNCIL, *Maintaining Standards*, paragraph 4.1

The specialist's recommendation for care must be made purely on clinical grounds in the best interest of the patient. A patient's disability alone is not adequate clinical grounds to refuse appropriate treatment.

Every patient, whether adult, child, or a person with physical or learning disabilities has the right to be dealt with compassionately and is entitled to expect a high standard of care.

See also *Good Surgical Practice*, The Royal College of Surgeons of England, November 2000, page 7.

Maintaining Confidentiality

> *The dentist/patient relationship is founded on trust and a dentist should not disclose to a third party information about a patient acquired in a professional capacity without the permission of the patient.*
>
> GENERAL DENTAL COUNCIL, *Maintaining Standards*, paragraph 3.5

It is the responsibility of the specialist to be aware of and employ the principles of the Data Protection Act (1998).

Similarly, it is the responsibility of the specialist to ensure that any computer system holding patient records is secure and registered under the Data Protection Act (1998).

All patient records are held in trust with the specialist and are confidential. These should not be released without the permission of the patient.

In cases where the specialist feels that, in the public interest, disclosure of records is justified, a defence organisation or professional adviser should be consulted first.

Records should not be given to solicitors, insurance companies or the police without the written permission of the patient.

Patient records, whether hard copy or electronic should be retained where possible for a minimum period of 8 years following the conclusion of treatment. This also applies for those who are deceased. Where records are to be disposed of, this should be done securely.

Communication with patients should not compromise patient confidentiality.

Patients have a right to access any health record containing details about that patient and their treatment (The Data Protection Act, 1998).

Guidance from the General Medical Council in 2000 on patient confidentiality and valid consent stated that it was illegal for doctors and hospitals to supply personal information on their patients to research projects or registries without first obtaining their permission. However, an amendment to the *Health and Social Care Bill*, 2001 establishes a Patient Information Advisory Group to which registries, who wish to be exempt from the Council's guidance on informed consent, can appeal. If exemption is recommended, the Secretary of State will approve a regulation to grant this.

Provision of Information

Only a dentist whose name is entered in a specialist list is entitled to use the title prescribed in connection with that list; no dentist should imply possession of specialist status in terms which could mislead patients.

GENERAL DENTAL COUNCIL, *Maintaining Standards*, paragraph 1.5

No publicity or advertising material should indicate that a dentist has specialist expertise unless the dentist is the holder of a specialist title and the dentist's name is entered in a specialist list. A statement to that effect may appear in publicity or advertising material. No other claim to specialist expertise should be made by any dentist.

GENERAL DENTAL COUNCIL, *Maintaining Standards*, paragraph 7.6

A specialist should not make a statement or declaration that is untrue, misleading or unethical. Specialists should ensure that any information published about the services they provide is factual, verifiable and conforms to the law.

If asked to provided details of specialist services for use by Trusts, other professionals or patients, specialists should:

- avoid any material that could be read as promoting procedures outwith their own expertise
- avoid denigrating others
- ensure that the literature provided by the institution, or corporate body, where the specialist works, does not make unreasonable claims.

Handling Complaints

If a patient has cause to complain about the service provided, every effort should be made to resolve the matter at practice level.

GENERAL DENTAL COUNCIL, *Maintaining Standards*, paragraph 3.13

Every attempt should be made to avoid patient dissatisfaction by:

- establishing trust, fully explaining the treatment and likely outcome and ensuring that the explanation is understood

- acting competently, courteously and with integrity throughout
- keeping full and accurate records
- immediately and openly declaring any mishaps and what will be done to rectify them. Apologise if appropriate. Accept responsibility if appropriate
- keeping a written record of any communication with the referrer, the patient, the family or carer.

If a patient wishes to complain:

- acknowledge the complaint immediately
- respond promptly, honestly and without prejudicing any continuing treatment
- co-operate fully with the complaints process within the required timescale.

Patients should be made aware of the current *NHS Complaints Procedure*.

Every attempt should be made to deal with complaints at a local level.

Specialists are recommended to contact their defence organisation at the earliest possible stage and prior to commencing correspondence.

Open, balanced and rational communication should be encouraged.

Personal Health

The conduct of a dentist who wilfully continues to practise when a physical impairment may be expected to prejudice the safety of patients may be regarded as serious professional misconduct.

GENERAL DENTAL COUNCIL, *Maintaining Standards*, paragraph 2.5

Complaints of drunkenness or the misuse of drugs, particularly if this involves an abuse of a dentist's prescribing powers, may lead to a charge of serious professional misconduct, even if the offence has not been the subject of criminal proceedings.

Problems with alcohol and/or drug dependency could lead to a dentist being referred to the Health Committee.

GENERAL DENTAL COUNCIL, *Maintaining Standards*, paragraph 2.2

A dentist who is aware of being infected with a blood borne virus or any other transmissible disease or infection which might jeopardise the well being of patients and takes no action is behaving unethically.

GENERAL DENTAL COUNCIL, *Maintaining Standards*, paragraph 4.2

If a specialist or a colleague is suffering from an illness or injury which affects judgement or performance or from an illness which could be transmitted to patients, it is their duty to seek and follow advice from an appropriate colleague.

Part 3

Multidisciplinary Team Working with Colleagues

Responsibilities for Standards in All Staff

A dentist should employ suitably trained and, where appropriate qualified staff.

General Dental Council, *Maintaining Standards*, paragraph 5.1

There is an obligation to utilise the knowledge and skills of other clinicians where appropriate

The Senate of Surgery of Great Britain and Ireland, *The Surgeon's Duty of Care*, *page* 5

TEAM WORKING

Team working is essential in present-day practice. Multidisciplinary teams comprise all those caring for an individual patient and include, for example, dental hygienists, therapists, nurses and technicians as well as other colleagues.

No specialist should work in their chosen field in isolation. It is acknowledged that those in specialist single-handed practice potentially work alone. They must therefore maintain regular professional contact with their peers.

Every specialist is responsible for the treatment of patients by trainee colleagues under their supervision.

(See also Training and Supervision, page 25).

RESPONSIBILITY FOR COVERING ABSENT COLLEAGUES

A particular area of team working responsibility is that related to a colleague's absence. Responsibility for patients under the care of an absent colleague must be accepted even if formal arrangements have not been made. It is preferable always to make formal arrangements for such cover. Handover of the continuing care of patients to a colleague (for example at the commencement of a vacation) should be fully understood by patients, the colleague, other staff and preferably recorded.

(See also Professional Responsibility Towards Protecting Patients, page 20).

Consultant Surgeons-Team Working in Surgical Practice, The Senate of Surgery of Great Britain and Ireland, May 2000.

Dealing with Medical Emergencies

Practitioners have an obligation to be conversant with current guidelines such as those issued by the Resuscitation Council (UK).

General Dental Council, *Maintaining Standards*, paragraph 4.7

It is the responsibility of the specialist to keep up to date with current resuscitation guidelines and to ensure that all members of the dental team are properly trained and prepared to deal with an emergency, including a collapsed patient. For full details of the requirements see The General Dental Council's *Maintaining Standards*.

Part 4

Training and Supervision

> *[Specialists] with special teaching responsibilities must develop the skills, attitudes and practices of a competent teacher. They must be honest and objective when assessing the performance of those they have trained.*
>
> General Medical Council, *Good Medical Practice*, paragraphs 8-10

DENTAL STUDENTS

Students should always introduce themselves to patients and ensure the patient is aware of their status Patients have the right to refuse to participate in student teaching and this must be respected.

TRAINEES AND TRAINING

Trainees must be supervised at all times.

Specialists should delegate clinical duties and responsibilities only within the competence of the individual trainee.

A named specialist must be available to cover clinical sessions and a rota published.

Assessment and appraisal of Specialist Registrars, House Officers, and other clinicians must be carried out regularly, thoroughly, honestly, openly and with courtesy.

The trainer should ensure that the trainee maintains a logbook which is accurate and regularly maintained, as required by the relevant training authority.

All trainers must have attended a course in training and in appraisal skills.

NON-CONSULTANT CAREER GRADE SPECIALISTS

Non-Consultant Career Grades (NCCGs) must only work under the supervision of a named consultant.

Delegated responsibilities, including the level of independent activity, must be clearly identified, agreed and fully understood by both parties.

The supervising consultant should define the level of supervision. It is the responsibility of the consultant to ensure the appropriate degree of supervision.

Consultants should support NCCGs in the continuation of their professional development, for example by attending courses and meetings.

LOCUM SPECIALISTS

Specialists must be vigilant concerning the standard of care provided by a locum member of their team.

If a locum specialist is appointed, the standards detailed in this document should be met. It is the responsibility of any specialist practising in the same specialty, or the specialty most closely associated with that of the locum concerned, to ensure that the locum:

- has attended a formal induction programme to include the routines and practices of the hospital or specialist unit
- is familiar with, and takes part in, the audit processes of the unit
- knows from whom to seek advice on clinical or managerial matters
- is aware of the need to practice similar standards of clinical care as the specialist
- is not isolated but included as a member of the specialist team.

A locum consultant must be on the relevant specialist list if full responsibility for care is to be accepted.

Part 5

Specialty Guidelines

The information included in this section is specialty specific. It is intended to supplement the generic guidance offered in the previous sections. As such, these specialty guidelines are not comprehensive and should be referred to in conjunction with the previous sections, rather than in isolation. Guidelines are constantly being developed and reviewed.

Surgical Specialties

ORAL AND MAXILLOFACIAL SURGERY INCORPORATING ORAL SURGERY AND SURGICAL DENTISTRY

Guidelines for Referral
The specialty provides a comprehensive diagnostic and surgical service for congenital and acquired disabilities affecting the mouth, jaws and face and of necessity manages the extension of such diseases into the surrounding tissues. Within this, surgical dentistry manages anomalies and pathological processes of the teeth and their surrounding structures with treatment normally carried out on an out-patient basis under local anaesthesia and, if appropriate, sedation.

Treatment Outcomes
Standard measuring tools including indicators of favourable and unfavourable outcomes are published on the British Association of Oral and Maxillofacial Surgery (BAOMS) website: www.baoms.org.uk.

Arrangements for Continuing Care
Medium to long term specialist care and supervision may be required for some patients. Appropriate arrangements should be made for this and communicated to both the patient and the referring practitioner who remains responsible for continuing general care during this period.

Records
Conventional contemporaneous record keeping of clinical history, investigations, diagnosis, treatment and follow-up should be kept along the lines of those followed for all surgical specialties.

Further Reading
In addition to the validated guidelines listed in Appendix 1 the following guidelines are published on the BAOMS website. Work on validating these is continuing.

- Dentoalveolar surgery including benign and cystic lesions
- Temporomandibular joint disorders
- Preprosthetic surgery and Implantology
- Orthognathic surgery
- Salivary gland disorders
- Head & neck oncology
- Cleft lip and palate
- Craniofacial surgery.

Orthodontics

Guidelines for Referral
The success of orthodontic treatment is dependent on patient co-operation. Patients being referred should show reasonable evidence of motivation and attention to oral hygiene. Treatment is seldom a priority for mild malocclusions and referrals to hospital based specialists should not normally be made for cases falling into IOTN[1] categories 1 & 2. On occasion patients not amenable to extensive orthodontic treatment may be referred for advice on extractions and other simple interventions.

Treatment Outcomes
The PAR[2] index provides a good general measure of the quality of outcome of orthodontic treatment in terms of the corrected occlusion.

Five year[3] and GOSLON[4] indices provide useful measurements of growth outcome in the treatment of unilateral cleft lip and palate cases.

Arrangements for Continuing Care
The following categories of orthodontic patients may need to be referred for tertiary continuing care:

- Cleft lip and palate patients who would normally be referred on to a specialist centre for cleft treatment
- Patients with severe disproportion of the craniofacial skeleton should be referred on to Oral and Maxillofacial surgeons for orthognathic surgery in conjunction with their orthodontic treatment and, where appropriate, complementary restorative care
- Patients with restorative dental problems, for example periodontitis, hypodontia, or endodontics, should be referred for a specialist opinion prior to commencement of treatment.

Records
The British Orthodontic Society (BOS) has produced a document entitled *Orthodontic Records: Collection and Management,* 1999 that deals with this issue and is available from the BOS office.

Further Reading
The British Orthodontic Society has produced advice sheets on the Orthodontic Treatment of Medically Compromised Patients, Materials, and Risk Management in Orthodontic Extractions. These are available from the BOS office. See also www.bos.org.uk

[1] *The Development of an Index of Orthodontic Treatment Priority,* European Journal of Orthodontics, 11, pp 309-320, P H Brook, W C Shaw, 1993

[2] *The Development of the PAR Index (Peer Assessment Rating): Reliability and Validity,* European Journal of Orthodontics, 14, pp 125-139, S Richmond, W C Shaw, K D O'Brien, I B Buchanan, R Jones, C D Stephens, C T Roberts, M Andrews, 1989

[3] *Study Models of 5 Year Old Children as Predictors of Surgical Outcome in Unilateral Cleft Lip and Palate,* European Journal of Orthodontics, 19, pp 165-170, N Atack, I Hathorn, M Mars, J Sandy, 1997

[4] *A New System of Assessing Dental Arch Relationships in Children with Cleft Lip and Palate, Cleft Lip and Palate,* Journal, 25, pp 314, M Mars, D A Plint, W J P Houston, O Bergland, G Semb, 1987

Paediatric Dentistry

Guidelines for Referral
The specialty provides comprehensive dental care for all children. This includes the detailed assessment and treatment for childhood oral diseases, dental injuries and anomalies. Referral of a child to a specialist for treatment should include a summary of clinical records and recent dental treatment as well as copies of existing radiographs.

Treatment Outcomes
The establishment of a healthy oral environment for the child that continues when the child reaches maturity. Prevention and treatment of oral problems together with the education of the child and their carers is of paramount importance in Paediatric Dentistry. Therefore, the specialist must regard prevention of oral disease and education of the child in appropriate preventive behaviour as the foundation of their clinical practice.

Arrangements for Continuing Care
Continuing care will be necessary for some patients. This should be organised, if necessary in liaison, with other specialists in the Community Dental Service, Specialist Practice and the Hospital Service; as well as with primary care practitioners.

Records

- A clear summary should be made in clinical notes, to include examination findings, a report of radiographs, treatment carried out and comment associated with models
- Oral hygiene, gingival and, where appropriate, periodontal indices to assist in monitoring oral health should be included
- Specialists in Paediatric Dentistry may require direct liaison with Paediatricians concerning the complex medical histories of some of their patients. Information concerning this and their drug regimens should be carefully documented.

Further Reading
In addition to the published guidelines detailed in Appendix 1. Other guidelines and policy documents of the British Society of Paediatric Dentistry are published in the International Journal of Paediatric Dentistry.

A series of competencies in Paediatric Dentistry is in the process of development for use in Specialist Registrar training.

Restorative Dental Specialties

RESTORATIVE DENTISTRY

Guidelines for Referral

Referral for diagnosis or opinion is at the discretion of the referring practitioner.

The prevention of oral disease is the cornerstone of specialist care within Restorative Dentistry.

- Referrals for advice, with appropriate supporting data, will always be accepted
- Referral data should briefly outline the nature of the problem, indicate points of significance, relevance to the referring specialist and provide additional information when appropriate

- Treatment acceptance in hospital practice will be based upon the complexity of care required and will normally be within the Complexity 3 component of the *Index of Restorative Dentistry Treatment Need*[1] (also at www.rcseng.ac.uk/fds)

- Priorities for treatment services are given to joint care with other specialists, patients with significant congenital or acquired oral abnormalities and those with disabilities.

Treatment Outcomes

Specific treatment outcomes are being developed together with the restorative dentistry monospecialties and the Clinical Effectiveness Committee of the Faculty of Dental Surgery, The Royal College of Surgeons of England. They are guided by the following principles:

- Overall health gain is paramount

- The objective of care is to maintain, together with the patient, a comfortable, functional, natural or restored dentition that is free from active disease and contributes to well being

Current outcome measures used are detailed within the monospecialty sections, Endodontics, Periodontics and Prosthodontics.

Records

Records must incorporate:

- A clear contemporaneous treatment strategy facilitating co-ordinated management

- A specific record of biomaterials used

- Where appropriate, labels or batch numbers should be retained and entered in the patient's notes

- Plaque, gingival indices and detailed pocket charts should enable health gain to be monitored

- The number and distribution of root canals should be noted, instrumentation and obturation procedures recorded

- Relevant, laboratory material and patient specific data should be retained.

Arrangements for Continuing Care

The referring dentist should receive following specialist treatment:

- A written account, copied to the patient, detailing the relevant future responsibilities of the specialist and the referring practitioner

- The report should include details concerning the frequency of maintenance visits, prognosis and suitability of individual teeth as future abutments

- Where appropriate, copies of radiographs taken by the specialist should be provided for the referrer to monitor long term healing

- The criteria for re-referral should be outlined clearly.

Further Reading

Further guidelines can be found in Appendix 1.

[1] *Developing an Index of Restorative Dental Treatment Need,* The British Dental Journal, 2001, 190, pp 479 - 486, H C Falcon, P Richardson, M J Shaw and B G N Smith

Restorative Dentistry Monospecialties

ENDODONTICS

Guidelines for Referral
Referral for root canal therapy should be restricted to cases where previous attempts have failed or there are technical difficulties such as fractured instruments, sclerosed canals or excessive root canal curvature. Referral for endodontic surgery is at the discretion of the referring practitioner, bearing in mind that endodontic re-treatment is the preferred option if possible.

Treatment Outcomes
Treatment outcomes should be reviewed one year post-operatively and annually thereafter for a period of four years. Outcomes are determined by clinical health and radiographic evidence of peri-radicular healing.

Further Reading
Consensus Report of the European Society of Endodontology on Quality Guidelines for Endodontic Treatment, International Endodontic Journal, 1994, Vol. 27, pp 115-124

PERIODONTICS

Guidelines for Referral
Referrals for periodontal treatment should usually be restricted to the following:

- Chronic Periodontitis when the Basic Periodontal Examination code is 4 or 4*
- Periodontitis modified by systemic factors
- Refractory Periodontitis
- Aggressive Periodontitis, localised and generalised forms
- Necrotising Periodontitis
- Prepubertal Periodontitis
- Necrotising Gingivitis that does not respond to initial treatment
- Desquamative Gingivitis.

Treatment Outcomes

Treatment outcomes should be reviewed by the specialist or within an agreed written protocol, by a general dental practitioner over a prolonged period. The period for review and reassessment may be lifelong. Outcomes are assessed by the following:

- The patient should have a comfortable and functional dentition
- Periodontal attachment levels should be stabilised
- Periodontal inflammation should be significantly reduced
- Intra-osseous lesions should show resolution on radiographs
- Clinically detectable biofilm (dental plaque) should be reduced to a level compatible with gingival health.

PROSTHODONTICS

Guidelines for Referral

Referring practitioners should provide a detailed outline of the problem, a history of the treatment to date, study casts and, where relevant, radiographs.

Treatment Outcomes

The following references are representative examples of treatment outcomes:

Long-term Marginal Peri-implant Bone Loss in Edentulous Patients, International Journal of Prosthodontics, 2000, 13(4), pp 295-302, G E Carlsson, L W Lindquist and T Jemt

Patient age and Long Term Survival of Fixed Prosthodontics, Gerodontology, 1993, 10(1), pp 33-39, P-O Glantz, K Nilner

Tooth-implant and Implant Supported Fixed Partial Dentures: A 10-Year Report, International Journal of Prosthodontics, 1999, 12(3), J Gunne, P Astrand, T Lindh, K Borg and M Olsson

Prevalence of Periradicular Periodontitis Associated with Crowned Teeth in an Adult Scottish Subpopulation, British Dental Journal, 1998, 185(3), pp 137-140, W P Saunders, and E M Saunders

Time Dependent Failure Rate and Marginal Bone Loss of Implant Supported Prostheses: A 15-Year Follow-up Study, Clinical Oral Investigations, 2000, 4(1), pp 13-20, K Snauwaert, J Duyck, D van Steenberghe, M Quirynen, I Naert

Records

Records should include:

- Detailed copies of treatment plan and costings when appropriate
- The shade, moulds and other details of artificial teeth together with the laboratory prescription
- The materials used in the construction of the appliances
- Materials used in cementation
- Size and make of implant components and the manufacturer.

Dental Public Health

Refer to the generic guidelines given throughout *Good Practice in the Dental Specialties.*

Oral Medicine

Guidelines for Referral

Referral to Oral Medicine units in the UK is generally for the diagnosis and non-surgical management of disorders of the oral mucosa, salivary glands, temporomandibular joints and orofacial sensation.

Treatment Outcomes

There are currently no specific indices for favourable or unfavourable clinical outcome of disease relevant to Oral Medicine. However detailed discussions of possible indices for pain and oral ulceration are available from sections of *Clinical Evidence*, British Medical Association, 2001 written by senior Fellows of the British Society of Oral Medicine.

Arrangements for Continuing Care

There are no UK-wide guidelines for the continuing care of patients with disease relevant to Oral Medicine. Each unit at present has its own arrangements.

Records

Record keeping is similar to other specialties.

Further Reading

Referral to Oral Medicine units:
Oral Malignancy and Potential Malignancy: Good Referrals Benefit Patients, Dental Practice, 2001; 39: pp 15-16, S R Porter, C Scully

Potentially Malignant or Malignant Oral Disease: www.doh.gov.uk/cancer/referral.htm

All other relevant disease:
Oral Ulceration – A Computer-Assisted Learning Package, Eastman Dental Institute and UK Department of Health, S R Porter, C Scully, D Pollard

Guidelines for the Management of Oral Dysaesthesia and Recurrent Aphthous Stomatitis: www.evidence.org/

Guidance on the Management of Oral Lichen Planus and Oral Mucositis are available from: www.cochrane.org/

Oral Pathology

Guidelines for Referral

Oral Pathologists support patient care by providing advice on diagnosis and investigation and by the provision of a diagnostic histopathology service.

Referring a Specimen for Diagnostic Histopathology

In principle, all tissue removed from a patient should be submitted for pathological examination. A possible exception to this is the examination of teeth routinely extracted for dental caries. It is recommended that biopsy should not be performed in general practice on lesions considered to be malignant on clinical grounds.

Specimens for examination may be delivered or posted to an Oral Pathology department using the following guidelines:

- tissue biopsies must be adequately fixed in an appropriate, labelled specimen container accompanied by a fully completed and signed pathology request form obtainable from the relevant pathology department
- requests for reports on lesions of bone should be accompanied by a copy of relevant radiographs. For special techniques or unusual specimens, clinicians are advised to seek the advice of their Oral Pathologist before carrying out the biopsy.

Specimens which are posted must be packaged in accordance with the current Post Office guidelines.

When an Oral Pathologist accepts a referral from another pathologist, it is usual to send stained and unstained sections or paraffin blocks accompanied by a request form or letter containing similar information. Pathologists may request previous biopsies or clinical information from other centres.

Advice on Diagnosis, Investigation and Patient Care

Oral Pathologists are frequently called upon to advise on the management of patients either in multidisciplinary team meetings or as an individual clinician.

Treatment Outcomes

A written report will detail the salient histological features and a definitive diagnosis or differential diagnosis. Advice regarding management or further tests may also be provided.

Arrangements for Continuing Care

Pathologists may refer specimens to specialist colleagues either for special tests or for expert opinion.

Records

Histopathology reports must be retained as part of the patient records. Oral Pathology departments retain copies of all reports whilst original tissue blocks and the slides prepared are archived for at least 10 years.

Oral Microbiology

Guidelines for Referral

The oral microbiologist should be available to advise on the appropriate collection and transport of specimens and assist the clinician in arranging any further special investigations that may be required.

Treatment Outcomes

Timely reporting of special investigations particularly for urgent diagnoses must be ensured. Where appropriate, feedback on the quality of the specimen should be included. It is considered good practice to include in the report details of any recent changes in microbial nomenclature.

The reports should be clear, accurate and easily interpreted. Oral microbiologists must ensure they are available to provide further information if required.

Arrangements for Continuing Care

Oral microbiologists are only infrequently in direct contact with patients and more often liaise with the relevant clinicians. Accordingly, they must ensure that they are readily accessible to clinical colleagues.

Dental and Maxillofacial Radiology

Guidelines for Referral

- It is essential that the referrer undertakes a history and clinical examination prior to any request for radiographs
- The referrer must supply the radiology (IRMER) practitioner with adequate clinical information relevant to the exposure to enable the practitioner to justify whether there is sufficient net benefit for the examination (exposure) to proceed. This is a requirement of *Ionising Radiation (Medical Exposure) Regulations*, 2000, Section 5(5) (see also 'Dental Radiography and Radiation Protection', page 18)

- Those working outwith hospital practice are referred to the *Guidance Notes for Dental Practitioners on the Safe Use of X-Ray Equipment*, 2001
- Those working in hospital practice are referred to *Medical and Dental Guidance Notes*

Treatment Outcomes

The radiographic examination should have a net benefit for the patient and will normally provide new information and lead to a change in the patient's management.

Quality targets have been recommended in the document *Guidance Notes for Dental Practitioners on the Safe Use of X-ray Equipment*, 2001:

- Standards range from 'Excellent' (Grade 1) to 'Unacceptable' (Grade 3)
- Each grade has a series of criteria based on patient preparation, exposure, positioning, processing and film handling
- Within the next three years, a standard of not less than 70% of exposures within Grade 1 will be expected.

Records

There is a legal requirement that there should be a clinical evaluation for all radiographic exposures. This means that there should be a written record (report) of each radiographic examination. The radiographs and/or other images are not part of the permanent patient case record and a decision regarding their retention should be made locally. The written report is part of the case record and should normally be retained for a minimum of 8 years following the conclusion of treatment.

Further Reading

Ionising Radiations Regulations, HMSO, London, 1999

Ionising Radiations (Medical Exposure) Regulations, HMSO, London, 2000

Approved Code of Practice, The Protection of Persons Against Ionising Radiation Arising from any Work Activity. The Ionising Radiations Regulations, HMSO, London, 1999

Guidance Notes for Dental Practitioners on the Safe Use of X-Ray Equipment, NRPB and Department of Health, 2001

Guidelines for the Use of Radiographs in Clinical Orthodontics, Second Edition, British Orthodontic Society, 2001

Selection Criteria for Dental Radiograph, Faculty of General Dental Practitioners (UK), 1998

Medical & Dental Guidance Notes, Institute of Physics and Engineering in Medicine (due for publication 2002)

Acknowledgements

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Appendix 1

Guidelines for Good Practice Published by the Dental Faculties and Specialist Associations

Adult Antimicrobial Prescribing in Primary Dental Care for General Dental Practitioners, Faculty of General Dental Practitioners (UK), 2000

Clinical Examinations & Record Keeping, Faculty of General Dental Practitioners (UK), 2000

Current Guidance for General Dental Practice, Faculty of General Dental Practitioners (UK), 2000

The Diagnosis and Prevention of Dental Erosion, Faculty of Dental Surgery, The Royal College of Surgeons of England, March 2001

Ethical Practice and Professional Conduct, British Orthodontic Society, 2000

Extraction of Primary Teeth - Balance and Compensation, Faculty of Dental Surgery, The Royal College of Surgeons of England, March 2001

Guidelines for Surgical Endodontics, Faculty of Dental Surgery, The Royal College of Surgeons of England, November 2001

Integrated Care Pathways of Oral Care for People with Learning Disabilities, Faculty of Dental Surgery, The Royal College of Surgeons of England and the British Society for Disability and Oral Health, July 2001

The Management of Patients with Third Molar Teeth, Report of a Working Party convened by the Faculty of Dental Surgery, The Royal College of Surgeons of England, September 1997

Management of Unerupted and Impacted Third Molar Teeth: A National Clinical Guideline, Scottish Intercollegiate Guidelines Network, September 1999

Methodologies for Clinical Audit in Dentistry Faculty of Dental Surgery, The Royal College of Surgeons of England, January 2000

National Clinical Guidelines, Faculty of Dental Surgery, The Royal College of Surgeons of England, 1997

- Management of patients with impacted third molar teeth
- Management of pericoronitis
- Management and prevention of dry socket
- Management of unilateral fractures of the condyle
- Management of the palatally ectopic maxillary canine
- Management of unerupted maxillary incisors
- Prevention of dental caries in children
- Treatment of avulsed permanent teeth in children
- Treatment of traumatically intruded permanent incisor teeth in children
- Continuing oral care – review and recall
- Screening of patients to detect periodontal disease
- Guidelines for selecting appropriate patients to receive treatment with dental implants: priorities for the NHS
- Restorative indication for porcelain veneer restorations
- Turning clinical guidelines into effective commissioning

Oral Management of Oncology Patients Requiring Radiotherapy, Chemotherapy or Bone Marrow Transplantation Faculty of Dental Surgery, The Royal College of Surgeons of England, July 1999

Orthodontic Radiographs – Guidelines, British Orthodontic Society, 2nd edition, 2001, K G Isaacson and A R Thom (eds.)

Paediatric Dentistry – UK, National Clinical Guidelines and Policy Documents, Faculty of Dental Surgery, The Royal College of Surgeons of England in collaboration with the British Society of Paediatric Dentistry, published by the Dental Practice Board for England and Wales, 1999

- Prevention of Dental Caries in Children
- Treatment of Avulsed Permanent Teeth in Children
- Treatment of Traumatically Intruded Permanent Incisor Teeth in Children
- Continuing Oral Care - Review and Recall
- Management and Root Canal Treatment of Non-vital Immature Permanent Incisor Teeth
- Diagnosis and Prevention of Dental Erosion
- Stainless Steel Pre-Formed Crowns for Primary Molars
- Management of Stained Fissure in the First Permanent Molar
- The Pulp Treatment of the Primary Dentition

Preventing Dental Caries in Children at High Caries Risk: Targeted Prevention of Dental Caries in the Permanent Teeth of 6-16 Year Olds Presenting for Dental Care, Scottish Intercollegiate Guidelines Network, December 2000

SAMS (Self-Assessment Manual and Standards), Faculty of General Dental Practitioners (UK), 1991

Treatment of Intrinsic Discoloration in Permanent Anterior Teeth in Children and Adolescents, Faculty of Dental Surgery, The Royal College of Surgeons of England, March 2001

Appendix 2

Dental Faculties of the Surgical Royal Colleges

Faculty of Dental Surgery
The Royal College of Surgeons of Edinburgh
10 Hill Square
Edinburgh EH8 9DW
Telephone: 0131 527 1608
Fax: 0131 527 1669
Website: www.rcsed.ac.uk

Faculty of Dental Surgery
The Royal College of Surgeons of England
35-43 Lincoln's Inn Fields
London WC2A 3PE
Telephone: 020 7869 6810
Fax: 020 7869 6816
Website: www.rcseng.ac.uk/fds

The Dental Faculty
The Royal College of Physicians and Surgeons of Glasgow
232-242 St Vincent Street
Glasgow G2 5RJ
Telephone: 0141 227 3220
Fax: 0141 221 1804
Website: www.rcpsglasg.ac.uk

Faculty of Dentistry
Royal College of Surgeons in Ireland
123 St Stephen's Green
Dublin 2
Telephone: 00 353 14022239
Fax: 00 353 14022125
Website: www.rcsi.ie

Faculty of General Dental Practitioners (UK)
The Royal College of Surgeons of England
35-43 Lincoln's Inn Fields
London WC2A 3PE
Telephone: 020 7869 6754
Fax: 020 7869 6765
Website: www.rcseng.ac.uk

Appendix 3

Specialist Associations

For full details of the Specialist Associations see *Quality Assurance for the Dental Specialties*, The Senate of Dental Specialties, 2000 available on The Royal College of Surgeons of England website at www.rcseng.ac.uk

British Association of Oral and Maxillofacial Surgeons
Telephone: 020 7405 8074
Fax: 020 7430 9997
Email: baoms@netcomuk.co.uk
Website: www.baoms.org.uk

British Orthodontic Society
Telephone: 020 7837 2193
Fax: 020 7837 2193
Email: awrightos@msn.com
Website: www.os.org.uk

Association of Consultants and Specialists in Restorative Dentistry
Telephone: 0114 271 7827
Fax: 0114 271 785
Email: enquiries@restdent.org.uk or R.I.Joshi@Sheffield.ac.uk
Website: www.restdent.org.uk

The British Prosthodontic Conference
Telephone: 01382 635980
Email: j.p.newton@dundee.ac.uk
Website: www.derwe.co.ukl/main/op_conf.html

See also:

British Society for the Study of Prosthetic Dentistry
Telephone: 353 21 545100 (Dr Finbar Allen, Cork Dental School and Hospital)
Email: finbarrallen@hotmail.com
Website: www.derweb.ac.uk/bsspd/

British Society for Restorative Dentistry
Telephone: 0161 275 6797
Fax: 020 7377 7687
Email: Serpil.djemal@Bartsandthelondon.nhs.uk
janet.harlow@man.ac.uk
Website: www.derweb.ac.uk/bsrd/

British Association of Teachers of Conservative Dentistry
Telephone: 0161 275 6731
Fax: 0161 275 6710
Email: Alison.qualtrough@man.ac.uk
Website: www.derweb.ac.uk/batcd

The British Endodontic Society
Telephone: 01494 581542
Fax: 01494 581542
Email: bes@atthomas99.freeserve.co.uk
Website: www.britishendodonticsociety.org

The British Society of Periodontology
Telephone: 01252 843598
Fax: 01252 844018
Email: besadmin@btinternet.com
Website: www.bsperio.org

British Society of Paediatric Dentistry
Telephone: 0151 334 5510
Email: lma@rabymere.demon.co.uk
Website: www.dentanet.org.uk/dentanet/prof/bspd2000html

Consultants in Paediatric Dentistry Group
Telephone: 0121 237 2826
Fax: 0121 237 2825
Email: L.Shaw@bham.ac.uk

British Society for Oral Medicine
Telephone: 0141 211 9629
Fax: 0141 353 2899
Email: David.Felix@scpmde.scot.nhs.uk
Website: www.eastman.ucl.ac.uk/bsom/index.html

British Society for Oral and Maxillofacial Pathology
Telephone: 020 7915 1055
Fax: 020 7915 1213
Email: P.Speight@eastman.ucl.ac.uk
Website: www.eastman.ucl.ac.uk.bsomp

Association of Clinical Oral Microbiologists
Telephone: 029 20742541
Fax: 029 20742442
Email: lewismao@cf.ac.uk

The British Society of Dental and Maxillofacial Radiology
Telephone: 0121 237 2780/2781
Email: p.g.j.rout@bham.ac.uk
Website: www.bsdmfr.org.uk

Consultants in Dental Public Health Group
British Association for the Study of Community Dentistry
Telephone: 01234 315765
Fax: 01234 315764
Email: sue.gregory@beds-ha.anglox.nhs.uk
Website: www.dundee.ac.uk/dhsru/bascd/bascd.htm

Appendix 4

Other Useful Contacts

British Dental Association
64 Wimpole Street
London W1G 8YS
Telephone: 020 7935 0875
Fax: 020 7487 5232
Website: www.bda-dentistry.org.uk

British Medical Association
BMA House
Tavistock House
London WC1H 9JP
Telephone: 020 7387 4499
Fax: 020 7383 6400
Website: www.bma.org.uk

Conference of Postgraduate Dental Deans and Directors
Postgraduate Institute for Medicine & Dentistry
University of Newcastle upon Tyne
10-12 Framlington Place
Newcastle upon Tyne NE2 4AB
Telephone: 0191 261 8275
Fax: 0191 232 3657

Continuing Professional Development Registration
Robert Brackenbury
The Royal College of Surgeons of England
35-43 Lincoln's Inn Fields
London WC2A 3PE
Telephone: 020 7869 6050

General Dental Council
37 Wimpole Street
W1G 8DQ
Telephone: 020 7887 3800
Fax: 020 7224 3294
Website: www.gdc.org.uk

General Medical Council
178b Great Portland Street
London W1N 6JE
Telephone: 0230 7580 7642
Fax: 020 7915 3641
Website: www.gmc-uk.org

Joint Committee for Specialist Training in Dentistry
Faculty of Dental Surgery
The Royal College of Surgeons of England
35-43 Lincoln's Inn Fields
London WC2A 3PE
Telephone: 020 7869 6810
Fax: 020 7869 6816
Website: www.rcseng.ac.uk

The Royal College of Pathologists
2 Carlton House Terrace
London SW1Y 5AF
Telephone: 020 7541 6700
Website: www.rcpath.org

The Royal College of Radiologists
38 Portland Place
London W1N 4JQ
Telephone: 020 7636 4432
Website: www.rcr.ac.uk

Appendix 5

Personal Professional Portfolio for the Dental Specialties

Appraisal must follow a standardised format if it is to be applied consistently to satisfy requirements for revalidation

Every specialist being appraised should prepare an appraisal folder. This is a systematically recorded set of all the documents: information, evidence and data which will help inform the appraisal process. The documentation will allow easy access to the original documents in the folder in a structured way, record what the appraisal process concluded from them and finally what action was agreed as the outcome following discussion

ADVANCE LETTER (MD) 05/01 Appraisal for Consultants Working in the NHS

The Personal Professional Portfolio is also available to download in PDF format on The Royal College of Surgeons of England website at **www.rcseng.ac.uk/fds** under 'Documents and Publications'.

Specialists employed as Consultants in the National Health Service have a contractual requirement for annual appraisal in accordance with *Advance Letter (MD) 06/00, 05/01.* For other specialists a Personal Professional Portfolio has been developed which includes a section entitled Practice Profiles. All specialists are recommended to maintain a Personal Professional Portfolio as proposed in *Quality Assurance for the Dental Specialties,* Senate of Dental Specialties, 2000. This will provide documentary evidence of good practice for the individual specialist and the practising environment.

1 Personal Details

Name:

Registered address (and contact address if different):

Date of Birth:

Qualifications (including date of primary qualification):

GDC / GMC registration number(s):

Type of registration and date(s) of first full registration:

Details of any break in registration:

UK specialist listing (detail specialty):

Date of entry onto UK specialist list(s):

Date and country granting specialist registration/qualification outside the UK and specialty in which registered

2 Details Of Current Clinical Activities

Details of all current professional practice, including grades of posts and institutions where appropriate with date(s) of appointment. A job plan or job description may be appended if relevant.

Fields of activity including:

- Sub-specialty/Monospecialty interests

- Managerial responsibilities

- Educational and teaching responsibilities

- Presentations and publications

- Research

- Other relevant professional activities

3 Keeping Up to Date

All specialists should record their continuing professional development and register with one or more of the following:

- Continuing Professional Education for the dental specialist scheme of the Dental Faculties and Specialist Associations
- Continuing Medical Education for the trained surgeon scheme of the Senate of Surgery of Great Britain and Ireland
- another Royal College scheme appropriate to the specialty

Specialists should also register with the General Dental Council scheme *Life Long Learning*: *Recertification for the Dental Professions* which has reciprocity for data collection provided that the format is matched with the proforma that can be accessed on the Council's website at www.gdc-uk.org. Specialists must satisfy these requirements for continuing professional development for continuing recognition when the scheme becomes mandatory.

Specialists registered with the General Medical Council must satisfy the requirements for revalidation.

4 Evidence about Standards of Professional Practice

Evidence for different individuals and different areas of specialist practice will vary. However it may be helpful to consider available evidence against the background of the General Dental Council's guidance for dentists on professional and personal conduct *Maintaining Standards* . Specialists are also strongly recommended to refer to the *Quality Assurance for the Dental Specialties*, The Senate of Dental Specialties, 2000 in relation to:

- Quality of clinical care

- Ethical and professional behaviour in all relationships with patients

- Multidisciplinary team working and relationships with colleagues

- Health

- Audit – arrangements for audit meetings and details of internal and external audit undertaken. Outcomes in relation to agreed national standards should be included where available.

Details of external peer review may include:

- Formal peer review by specialty colleagues

- visits from Royal Colleges, Specialist Advisory Committees, Postgraduate Dental Deans and other accrediting bodies.

- Participation in specialty group activities

- Formal postgraduate training and education

- Details of supportive feedback from patients and colleagues with whom you have worked and colleagues from whom you have accepted referrals.

- Details of perceived problem areas, which may undermine your ability to deliver high quality care, including any adverse service conditions and personal health problems.

5 Practice Profile

Written Practice Protocols and Procedures

Staff Responsibilities

Patient Information Documents

COSHH information and risk assessment

Health and Safety Policies and Procedures

Health and Safety Practice Policy Statement

Staff Responsibilities

Infection Policies

Medical History Form

Location of important items (Fire extinguishers etc)

CPR Management Procedures

Sharps Injury Protocol

Fire Evacuation Procedures

Practice Profile continued

Ionising Radiation Protection

Health and safety information and documentation

Evidence of equipment checks e.g. compressors and autoclaves

Data base of patients data protection registration

Arrangements for disposal of clinical and trade waste

6 Details of Personal Development Plan

- Areas for development

- Objectives for the following year

- Programme to improve the practice

7 Summary of Annual Appraisal

- Quality of clinical care

- Ethical professional practice

- Team working with colleagues

- Health

- Practice profile

- Miscellaneous

Appraisee

Signature:.....

Name:.....

Date:.....

Appraiser

Signature:.....

Name:.....

Date:.....

This publication is available on The Royal College of Surgeons of England webstie at
www.rcseng.ac.uk/fds
under 'Documents and Publications'.
The Personal Professional Portfolio is also available to download in PDF format.

Senate of Dental Specialties

Membership

Dean, Faculty of Dental Surgery, The Royal College of Surgeons of Edinburgh
Dean, Faculty of Dental Surgery, The Royal College of Surgeons of England
Dean, The Dental Faculty, The Royal College of Physicians & Surgeons of Glasgow
Dean, Faculty of Dentistry, The Royal College of Surgeons in Ireland
Dean, Faculty of General Dental Practitioners (UK)

Specialist representatives nominated by the following bodies:

British Association of Oral and Maxillofacial Surgeons
British Orthodontic Society
Consultant Orthodontists Group
Association of Consultants and Specialists in Restorative Dentistry
British Prosthodontic Conference
British Endodontic Society
British Society of Periodontology
British Society of Paediatric Dentistry
Consultants in Paediatric Dentistry Group
British Society for Oral Medicine
British Society for Oral and Maxillofacial Pathology
Association of Clinical Oral Microbiologists
British Society of Dental and Maxillofacial Radiology
Consultants in Dental Public Health Group

Chairman, Clinical Effectiveness Committee, Faculty of Dental Surgery, The Royal College of Surgeons of England

Chairman, Postgraduate Education Committee, Faculty of Dental Surgery, The Royal College of Surgeons of England

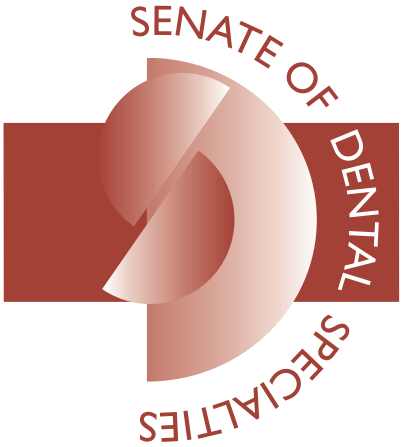
Chairman, Conference of Postgraduate Dental Deans and Directors (COPDEND)

Chairman, Joint Committee for Specialist Training in Dentistry (JCSTD)

Chairman, Joint Committee for Continuing Professional Education of the Dental Faculties and Specialist Associations (JCCPE)

General Dental Council, two observers, one of whom is a lay member.

Good Practice in the Dental Specialties



SENATE OF DENTAL SPECIALTIES
The Royal College of Surgeons of England
35 - 43 Lincolns Inn Fields London WC2A 3PE
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E-mail: fds@rcseng.ac.uk
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