Just for the record. . .

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I was interested to read the paper by R.G. Morgan in this issue of the *BDJ* because it was a poignant reminder of my own experiences in practice many years ago. The paper is on the evaluation of clinical records in a group of dental practitioners entering a quality assurance programme. The findings are that quite a number of UK dentists, like dentists in other areas around the world, are not keeping basic adequate clinical records. For me though the really interesting part of the paper were the findings on periodontal records, because this was an area I focused on in my own practice.

The details of the research are worth noting. Forty seven general dental practitioners were involved and all were being assessed by BUPA DentalCover at the time. While they were not representative of UK dentists as a whole I think they could be expected to be reasonably competent at the clinical care of patients and aware of good general standards. From this sample a total of 464 clinical records were examined and from that sample only 96 of the records included periodontal screening (20%). Interestingly although 16.6% of those who had been periodontally screened had moderate to severe disease, only seven records contained some form of pocket depth (probing depth) charting.

The paper reports on other findings, some of which are quite worrying (such as the fact that only 70% of the records examined contained full tooth charting and less than half had a completed medical history); but my own interest, as stated earlier, was focused on the periodontal aspects and reading this paper had stirred up some painful memories. These memories were directly linked to my search for knowledge to enable me to focus on periodontal care in my own practice, resulting in my accepting a part-time position as a lecturer at The Royal London in the Department of Oral Medicine and Periodontology. I was soon to discover that the level of knowledge I had acquired from attending postgraduate courses on periodontology was totally inadequate for teaching undergraduates. I had to work hard to increase my knowledge base.

But the more significant realisation I had to accept (and it was not an easy acceptance) was the fact that I was teaching one standard of care to the students but practising a different standard of care in my practice. It would have been all too easy to simply remind myself that the NHS fees prevented me from offering the same standards in my practice as the standards in a teaching hospital, but that was too convenient an excuse. I felt I needed to raise my standards yet at the same time ensure I was able to run my NHS practice as a profitable business.

My answer came, interestingly enough, in my approach to periodontal clinical records. I devised a system of periodontal monitoring that was feasible within the NHS scale of fees (at that time) yet provided me with far more useful information than I had ever had in the past. For the first time I really appreciated the value of periodontal records, and in a wave of missionary zeal I embarked on a series of lectures to 'bring the message' to the rest of my fellow practitioners. To my surprise only a few seemed to believe that periodontal monitoring was as beneficial as I had found, despite my heroic efforts to persuade them otherwise. I had not then learnt that change has to come from within.

The whole experience left me with a number of questions to which I still have no answer, and the paper by R.G. Morgan only helps remind me. Why could I not see the benefits of good clinical records until I was involved in teaching undergraduate students? Why is periodontal monitoring not taught to students in a way that makes it both useful and feasible? How can we honestly continue to profess we are a caring profession when (worldwide) the most basic clinical records are not being recorded? I wish I knew the answers.

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