The role of a specialist in periodontology

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Key points

- Details when a dentist should refer a patient with periodontal disease to a specialist.
- Describes questions that can arise when a patient is referred for specialist dental treatment.
- Highlights what is necessary of the referring dentist to minimise potential dilemmas.

Abstract

Periodontal disease is prevalent in many patients who attend general dental practice. However, the population is generally unaware of the disease until there is either the prospect of losing their teeth, not being able to have orthodontic treatment or advanced restorative treatment. Most patients should, however, have their condition managed within primary dental care, and clinical studies have shown that non-surgical treatment is a highly effective method of periodontal therapy. Treatment of periodontal diseases involves monitoring the response to initiated treatment and reacting accordingly. A general practitioner's, or hygienist's, decision to treat or refer would largely depend on the clinician's ability (determined by their training and experience) and financial implications within the constraints of the NHS or other care plans. This referral may be to a more experienced practitioner, a specialist or to a teaching institution.

Introduction

The relationship between a specialist and a referring general dentist should be a special one. Both partners are reliant on each other, but it can sometimes raise some ethical dilemmas. While the specialist relies upon referrals from the general dentist for his/her livelihood, the referring practice can often present the specialist with difficult practice situations. The specialist must consider what is best for the patient while also remembering that they depend on the referring practitioner for their caseload. The loss of a referring practitioner can result in the loss of thousands in practice income for the specialist.

The role of a specialist

An example of a scenario and the questions it raises (which may seem remote to most general dentists but can be faced by the specialist daily) are highlighted below:

A patient is referred for crown lengthening or gingival recession treatment. Prior to treatment, the specialist becomes aware that other areas in the mouth may require more urgent attention (poor general periodontal condition, active caries or faulty restorations/prosthesis). The questions that arise are:

- Should the specialist merely carry out the procedure despite being aware of other areas of oral diseases being left without necessary treatment? This kind of ethical dilemma is more problematic when the referral involves implant therapy
- Is it the specialist's job to prioritise treatments in cases where the patient's financial resources are limited? This could mean the specialist's treatment is postponed, delayed or cancelled
- Is it the role of the specialist to help the patient and the referring dentist in highlighting the relative need for other treatment? More importantly, how does the specialist carry this out in a way that does not embarrass the referring colleague?
- In this case, is the specialist obliged to directly inform the patient of the finding or is communication with the generalist enough? How, or how much, does one inform the patient to offer adequate legal protection to the specialist?

Sometimes there are situations when there is no unity between the 'right thing to do' and the treatment planned for the patient. Most of the time these ethical problems can be minimised or avoided by having a more patient-centred approach and a working relationship with the referring dentist. The following highlights what is necessary of the referring dentist to minimise potential dilemmas:

- A general dentist should provide a basic diagnosis and any nominal treatment in their own surgery. A BDS degree means that a general practitioner should have the skills to perform basic periodontal treatment or at least recognise the problem. An increase in the number of patients with periodontal problems, and the intimate relationship between periodontology and restorative dentistry, necessitates a greater understanding and an increased level of understanding on the part of the general dental practitioner. The British Society of Periodontology (BSP) has various guidelines which help practitioners with the 'triaging' of the patients

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- A general dentist should not be shy of asking the specialist for help in the management of their patients
- When the patient agrees to a referral, taking a few extra minutes and talking with the patient (or asking appropriate staff to) about what to expect helps considerably. Providing patients with a brochure or a relevant website address (BSP, American Academy of Periodontology or even the specialist's website), for instance, should help their understanding. Referring a well-informed patient who understands what the specialist treatment would involve and what is required of them after the treatment is carried out, is beneficial
- The patient should be encouraged to return for specialist recall appointments. Periodontal disease treatment involves a lifetime of surveillance. All practitioners should recognise recurrent periodontitis during maintenance/supportive therapy and provide interceptive treatment to avoid cases of 'supervised neglect'
- Most of all, general dentists need to communicate effectively with the specialist.

Success as a specialist depends on being able to focus on both the patient and the referring dentist. The key to a successful referral relationship is good communication and proper patient preparation.

Many specialists play a role in providing education to those training to become specialists and other dental care professionals in hospital and schools. Some hold local study clubs and open evenings at their practice. Most of the periodontal specialists who work within the primary care setting are based in independent practices, and treat and provide care for patients that have been referred internally within the practice as well as accept referrals from other dental practices.

A specialist in periodontology needs to have a good grasp of not only oral medicine (as many patients tend to be walking chemical factories and not least there are possible systemic and drug associations) but also be aware of current trends and treatments of other disciplines of dentistry including orthodontics and prosthodontics.

The path to becoming a specialist, however, is fraught with difficulties. Currently, the specialists in the disciplines of endodontics, prosthodontics and periodontology must enrol into a recognised training programme currently offered within a university setting. The majority are now self-funded and at a considerable financial cost. Acceptance onto the course is by competitive entry and the end of the training is noted by successfully achieving MRD (Membership in Restorative Dentistry) via examination. This, together with satisfactory progress through Annual Review of Competence Progression process, would result in awarding of Certificate of Completion of Specialist Training which enables automatic entry onto the GDC specialist register. The alternative option for those who cannot completely fulfil these requirements is via a mediated entry, which is currently a more difficult path.

Currently there are very few specialists within primary care settings who can provide service under the NHS. The desire by Heath Education England and the Chief Dental Officer to have level 2 practitioners who have enhanced skills may well offer opportunities for more work to be carried out in primary health care settings. Many teaching institutions now run part-time courses leading to a master's degree in various subspecialties.

A key question is will there be a role for specialists in the future? A specialist employed within the NHS would be supporting level 2 practitioners and providing governance. Such networks have already been set up for oral surgery and orthodontics. This ensures that level 2 practitioners do not work in isolation but are part of the locally organised networks. In addition, the terms of reference for the managed clinical network (MCN) at area-wide level procures that it is chaired by a specialist or a consultant. There are certainly some challenging and interesting times ahead.