Endodontic rumours

Some dentists think NHS funding for Endodontics is ‘laughable’. But is it a fact or just Chinese whispers that some GDPs are opting for extractions instead of endodontics because of budget contractions? If this is true, what are the implications? Dental Tribune investigates

**Endodontics** is often identified as one of the most technically demanding procedures in general dental practice, dealing as it does, with tooth pulp health surrounding the root.

Some dentists claim that the technical know-how required for complex root-canal treatment is not acknowledged by the NHS, which classes complex endodontic treatment under the same band as fillings.

A dentists’ questionnaire on website, bassettlaw.gov.uk put forward the following: ‘We are now target driven – we have to earn a certain number of UDAs per year. In the past we simply provided the treatment required and got paid for it. Now, we get the same UDAs if a patient needs one filling or six extractions, eight fillings and three root treatments. It is obvious that dentists have a disinclination to accept patients with dreadful mouths.

‘There should be a more flexible approach to UDAs and poor mouths should attract more. UDAs should be awarded in relation to the treatment provided.’

Dr Shiv Pabary, the principal of six practices across Newcastle and Gateshead, which have been established over 20 years, says the situation is complicated. He says: ‘With regard to endodontics, the way the contract is set up, it is assigned to Band 2. But to do treatment properly can take up to 90 minutes and be very demanding. I don’t know what the evidence is that dentists are opting for extractions in practice, but the current system definitely discourages dentists from saving teeth.

‘There is also a strong ethical dimension, because dentists should be doing what is in the patient’s best interest. A dental practitioner would have to strongly defend a decision to extract a tooth, if it were not in the patient’s best interests.

‘In our practices we went into a PDS contract early. I told my colleagues not to change their treatment plans or their way of thinking, because dentists are obliged to do what is clinically necessary.

‘For example, if there is a second or third molar from the back that is non-functional, one could consider extraction as a possible option. But if a patient needed three molar endodontic treatments, the dentist would only get

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Predictable Endo for the General Dental Practitioner

smartseal are delighted to announce dates for their popular evening seminars. The events will be hosted by Jerry Watson BDS, a practising GDP from Lincolnshire.

Aim of the course
To provide course participants with the necessary knowledge and skills to be able to implement the smartseal endodontic system in their practice.

Course objectives
By the end of the course participants should:
- have an understanding of the science behind the smartseal system
- have knowledge of the polymer plastics used in the system
- have the necessary skills to be able to use the smartseal system
- understand the nature of the material and its uses
- be able to interpret x-rays where a smartseal endodontic treatment has been used.

Format of the evening
6.30pm light buffet/networking with colleagues
7.00pm overview of the system, science behind the smartseal system
9.00pm close

Dates and venues
21 May Milton Keynes
03 June Glasgow
02 July York
17 September Chesterfield
24 September Cardiff
08 October Ipswich
26 November London

Delegate rates: £55 - dentists, accompanying nurse free of charge*. Delegates attending the seminar will receive a 50% discount against the purchase of an introductory pack of smartseal; one nurse per dentist

About the speaker: Jerry Watson is a general dental practitioner based near Stamford. Jerry is a well respected trainer and has worked with many companies and organisations to deliver training for dental teams; he is particularly interested in facilitating customer care and team work training events.

Delegates who attended the recent spring series of seminars made the following comments following their experience at the seminar: "uplifting", "looking forward to getting started with smartseal" and "it does as it says on the tin it will be amazing, I think it will and does".

Endodontics should be introduced, because dentists should be fairly remunerated for it. Endodontic instruments are all single-use, which also increases expenditure.

‘If a crown gets 12 UDAs, a molar root-canal treatment should get nine and an anterior tooth, at least six. That would encourage more dentists to do root-canal treatments rather than bridges. NHS dentistry has been turned back half a century because of it.

Another point is that young, highly-trained dentists, who are not doing Endodontics because of the disincentive under the new contract, are not necessarily more skilled if they do not practice the technique.

‘But saying that, it hasn’t been an issue in our practices and we do provide Endodontics where clinically necessary. We won’t change the way we think about what is necessary for patients and in this way, might make a bad system work.

‘The NHS really does need to look at Endodontics again.’

Nick Patsias, vice-chairman of the London Federation of Local Dental Committees, thinks there are some ‘unfortunate perverse incentives’ in the new contract. He says: ‘The way the fees are set up, the DHs incentivising dentists in the direction of simpler treatments. Dentists are being financially encouraged to do easier treatments such as extractions rather than root-canal dentures rather than bridges. NHS dentistry has been turned back half a century because of it.

‘I wouldn’t like to say whether dentists are actually doing that, some could be and others are definitively not. But it is counter-productive that an NHS dentist receives the same fee for however many root canal treatments he carries out. The contract needs changing.

‘Another major perverse incentive is that the patient-charging structure encourages them to leave their treatment for as long as possible until they need a lot of work. This is at the expense of the regular patient who pays the same fee for only one filling or crown. This, along with the nice guidelines, which recommends recalls of up to two-year intervals is giving the wrong message to patients and dentists alike. After decades of trying to get our patients to the dentist more regularly, now the message appears to be, stay away, you will be better off!’

Dr Gurpram Singh Lidder, principal of two practices in Dunstable and Leighton Buzzard, says the UDA system needs to change but it was important to acknowledge technology’s positive impact: ‘I think dentists should receive more UDA accreditation for root-canal treatment, which is currently paid the same as fillings, but is far more complex and time-consuming.

Three UDAs is rather paltry. Another band with more UDAs for molar root-canal treatment should get nine and an anterior tooth, at least six. That would encourage more dentists to do root-canal treatments rather than bridges. NHS dentistry has been turned back half a century because of it.

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nored that this could be partly canal work, because it needs to be acknowledged as an advanced restorative procedure that requires a high degree of skill.

‘The current system can put pressure on dentists to extract teeth, rather than restore them.’

‘However, if statistics do show more extractions, it cannot be ignored that this could be partly due to the new opportunities that have opened up because of implants. For example, a tooth of dubious prognosis, which previously one may have restored and warned the patient about its limited prognosis can now be extracted and replaced with a much longer-lasting, more predictable implant.

‘We are lucky to be in a fairly affluent area here, so can make up the cost of Endodontics through private work with some of our patients. But in a poor area, where there is minimal private treatment, the cost of root-canal treatment cannot be made up, which could encourage more extractions.

‘Not acknowledging the complexity of endodontics devalues the work dentists do.’

Mark Pulford, commissioning dental lead for Heart of Birmingham Trust PCT, says the PCT does provide Endodontics. He adds: ‘We recognise that Endodontics is an issue, but having said that, this PCT is providing Endodontics. We will be working with our dentists including, and in particular, dentists with an interest in Endodontics, to see if we can support services in HORT, through a clinical network approach involving High Street dentists and secondary dental care colleagues. This is in order that future contracting can be influenced by our dentists, now that we are more than two years into the new contract. Our work will include looking at contract values and we certainly will not be paying any less.’

An endodontics expert said endodontics and the NHS was a very delicate topic which needed attention from political, social and economic viewpoints.

He said community health covered the whole of society and implied the primary right of the ill individual to be helped and re-integrated back into society. He says:

‘Endodontics is a dental speciality, which covers the treatment of healthy or infected pulp and periradical diseases. Each diagnostic requires a different treatment approach.

The more advanced the disease, the higher the qualification requirements for the practitioner, the higher the material...
and instrumental involvement, the higher the time demands and, of course, the financial implications.

Endodontic treatment of a multiple-rooted tooth, presenting a chronic apical periodontitis, may require between one and half to two and a half hours of clinical work. Financial remuneration as offered by the NHS cannot cover this.

The NHS recognises the need for differentiation and accordingly covers treatment costs for GDP and endodontic specialists within the funding available. As science advances, the previously allocated funding cannot continue to cover the costs, but one cannot blame the system for not providing funding for everything.

Offering the patient an up-to-date diagnosis and all available treatment options, including the coordination of specialist referral services, represents the optimum standard of NHS care. 1

Eddie Crouch, secretary of Birmingham CAMPAIGNING GROUP, Challenge, said the Department of Health included funding for Endodontics in the contract value, but he adds that, ‘the funding was based on a year that may have been typical or atypical.

“If a dentist is now seeing more NEW patients with higher treatment needs and therefore more endodontic treatment is required as a result, then the UDA system cannot recognise that.

The DH wants more dental access for patients, but it must recognise the effects on contractors.

“IT is no surprise that when dentists are faced with a target, they aim to achieve it by trying to get as many UDAs as quickly as possible. They can achieve this well through extractions, but root fillings do not get the same results so quickly.”

Specialist in Endodontics, Jerry Watson said there had been a marked decrease in endodontics in the NHS. He adds: “To my knowledge the decay rate has not changed significantly, it therefore follows that more extractions are being performed to alleviate pain. This situation is not in the patient’s best interest, as the cost of replacing long term tooth loss is much greater.”

In response to the views, Barry Cockcroft, chief dental officer for England, says dentists in general were earning more under the new system. He says: “All the IC data published shows no increase in extractions. A reduction in complex work, providing it is appropriate, is one of the aims of the new system.

“We need to start looking forwards, focusing on the massive change going on regarding the growth of prevention, the increased number of new dentists coming out of UK dental schools and the commitment made by the NHS to commission enough services to enable anyone who seeks NHS dental care to get it by April 2011 at the latest. There is a huge increase in preventive work, backed up by evidence.”

He said ‘preventive toolkits’ had been distributed to every practice and there was a 153 per cent increase in fluoride-concentrated toothpaste, as well as evidence-based programmes using fluoride varnish.

Dr Barry Cockcroft has agreed to answer any questions our readers would like to raise on this subject matter. Simply email your queries to penny@dentaltribuneuk.com and we will publish his responses in a future issue.
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The meetings commence

Existing Bank arrived. There were two of them and they were nice and pleasant. They built rapport fairly well, although they were questioning me on what I did as a business. Twenty years as a customer, yet they did not know what I did for a living. They offered a really good scheme and I said that I could think it over with my wife.

New Bank arrived on time. There was just one of them and he was called Brian. Brian spent the first few minutes asking me lots of questions about my business and my website, which he had visited the day before, and about some of the training I had delivered. We must have spent at least 20 minutes discussing my business and my life, and I was in my element.

What's happened since

1. One of his associates came and collected the forms and all necessary paperwork within 24 hours.
2. I had regular telephone calls from his PA, Stephanie, every other day, informing me of the progress of the loan.
3. Once we had completed, I got a telephone call telling me the money was ready and available to spend.
4. A few days later I got a bunch of flowers thanking me for my business and for choosing New Bank.

It was harder to do business with New Bank, as I had to provide information that my existing bank already had, however it was a joy to do business with them.

You see, ‘ME’ is my favorite conversation. He asked me questions about what I required and presented some quotations he had already prepared on the basis of a quick telephone conversation we had had on the day before. You know what, I had already decided to do business with Brian and New Bank before I had seen the offer he was making to me. I was very impressed and I had probably decided in about five minutes.

Why, because Brian had taken the trouble to find out all about me, before he came to see me and was genuinely interested. We also found several topics we had in common, before he came to see me. He was called Brian. Brian spent about some of the training I had delivered. We must have spent at least 20 minutes discussing my business and my life, and I was in my element.

I find in life that for every 100 purchases/transactions I make, about three to four per cent are memorable and enjoyable. The other 96 per cent are nothing special, or the service is not good and I do not enjoy it. So I am delighted to share one of the more enjoyable experiences.

Key points to learn

1. Spend time in preparation. Learn all about your patients, read their records and have staff meetings. Remember – proper preparation prevents poor performance.
2. Really focus on getting the customer to like you and ‘connect’ with the patient. It is only when you really connect that a transaction takes place.
3. Look the part. Nothing more to say here.
4. Once you have gained commitment, do everything possible to make the experience a great one. ‘Wow’ them at every opportunity, keep them updated with what is going on and of course, common sense here, thank them for your business.
5. Ring the patient at home afterwards and ask them how everything is going.

Last thought and something I would like to leave with you. Please focus on building relationships with your patients. You and your team will never get a second chance to make a first impression. It is only when you really connect that a transaction will take place.