An interview with Gordon Laurie BDS, a Specialist in Special Care Dentistry

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Why did you chose to become a dentist?

I don't know. My usual answer to patients is that I was really drunk and woke up in dental school (laughs). I wanted to do something that involved working with people, I'm kind of a people person. I wanted to do something that involved working with my hands, so dentistry seemed like a happy medium that let me work with my hands, and let me work with people. And it seemed to kind of fit it all and so I did that. It wasn't a conscious decision, I didn't decide that's what I want to do.

My older son is an anaesthetist and that's what he wanted to do since he was in the primary six. He was totally focused, that was his plan**,** that's what he wanted to do and has always done, I was never like that, I just kind of fell into dentistry. And even the dentistry part of it, for my first five years I worked in a general practice with somebody else and I realised that I didn't like it and I wasn't even good at it either so I kind of fell into the special care stuff that seemed to just suit me and I started doing that and thought this is actually what I enjoy. That's how it happened.

What part of your job was working with dental phobics?

Dental phobics wasn't a main part of my job but something that just happened. My responsibility was special care; people with learning disabilities, complex medical problems, mobility issues, housebound people who couldn't get to a dentist and phobics was just maybe one tenth of that. So I was quite happy to do it but never felt it was a big part of my job.

It's interesting how things have improved over the last twenty years. When I first started out, there was virtually no sedation available. When I was in general practice I did a bit of IV sedation, one of my bosses did it and I did the dentistry. I'd seen inhalation sedation being used as a student but I'd never done it and you just couldn't get it if you were a dental phobic, there was nothing.

Some practices would offer some IV, but mainly for private patients and there was no central system and no direction on how to handle dental phobics. When the Special Care

Team got set up, practices were invited to refer patients in for treatment, they started referring in dental phobics too (of course!)

So we just had to get on with things, but there was no provision whatsoever for patients with those kind of needs, just a dentist with a sympathetic ear and some time to try to talk patients around. It's good that things have improved. Hopefully we'll bring up a generation of children that don't need sedation at all.

So you specialised in special care dentistry quite early after you qualified?

About nine or ten years later. I'd been working in general practice for a while and then I got a job in the Community service in Ayrshire and I worked at what we called the routine service; doing school inspections on school children out in the community and then there was the first dedicated special care service in Scotland and I volunteered for that and got accepted for it and that's where I started from.

That was a long time ago now and then the sedation stuff grew on from that, we didn't have it to start with and were pressed to be able to give sedation so training courses were sort of provided for it, but in those days my IV sedation training was one on one with an anaesthetist showing me how to cannulate and an afternoon of me putting the IV sedation drugs into the patient and him saying that's fine and off you go. That was it. And inhalation sedation wasn't even as much as that, it was turn that dial, turn that dial, patient looks happy, off you go. Sounds kind of scary, but that's what it was. Eventually formal training courses were available, but I had been doing sedation for about five years before I actually had a formal training. So you can see the transformation. And as an aside, when I qualified in dentistry we were still taught how to give general anaesthesia and then simultaneously being told not to do it. They had to teach us, it was a part of the curriculum but you mustn't actually do it.

General anaesthesia in dentistry has came a long way too, about 40 years ago, dental anaesthesia was done in the dental surgery. When I first qualified, a local medical GP came into the surgery and gave the anaesthetic, but then it developed into we did them in a dental surgery in a hospital and finally it was moved into being performed in proper operating theatres. With a consultant anaesthetist providing the anaesthesia, but it took years for that to happen. As well as several deaths unfortunately.

How was your experience with dentistry in US?

I visited a few practices when I was on my holidays over there, I'm sad that way, if I know a dentist in a foreign country then I try to visit their practice, I need to get a life really! What happened in the practices I visited was, they generally have a dental assistant stay with the patient all the way through, the hygienist would come in and see the patient, put local anaesthetic in, goes away, and then the dentist would come in and cut the cavity out and the dental nurse would fill it and away the patient goes.

The dentist has about three or four surgeries they're working in continuously so you just go round, cutting cavities and not seeing anything else.

It's probably the most efficient way of working but I couldn't stand it, to me the most interesting thing about dentistry is the patients. Talking to them and getting to know them, see how they're doing not; just doing dentistry, that's not for me.

Not all dentists in America work like that of course, but a fair number do and the ones I visited did.

What about sedation in America?

My experience of it was that it was very expensive and not that very well integrated into general practice. Some dentists will do inhalation sedation, others IV sedation, but they tend to limit that more to oral surgery practices, not many general practitioners do sedation.

They tend to use what we call polypharmacy in IV sedation, in other words, they'll use multiple drugs, not just Midazolam, but throw in some opiates such as Fentanyl too, that's routine in a lot of American sedation practices, whereas in the UK it's very frowned on to use more than one drug at a time.

It's very expensive and not a lot of insurances will cover it so it's difficult to get, general anaesthesia is a real problem as well. If, for example, you've got someone with a profound learning disability who needs general anaesthetic for treatment, it's going to be very expensive and they wouldn't have insurance to pay for it. That's how the American system works unfortunately.

I feel like even if someone has the money, it's not so easy to find a nervous-patient friendly dentist in America, it seems to be an aspect that gets hugely ignored, because they need to keep the numbers up, because it's a production line basically, constantly turning over patients to make money.

The thing is, in America, when you qualify as a dentist, you're probably going to have about a million dollars of debt. And that has gonna be serviced somehow so you're going to be needing to make some good money to pay that off. Over here, yes, students graduate with some debt… but it's not the same level so there is a whole financial side of things in The States that we don't have here. Fortunately.

To make a lot of money in dentistry you have to be doing a lot of work and it's mostly what we call piece work, you get paid for what you do.

The problem used to be in the NHS that the government would work out how long it would take to do something and set a fee appropriately; so if a dentist earns let's say 50,000 Pounds a year, they would set the fees and divide it on the items of treatment. They would roughly work out how long it would take to do something and then they

would pay you according to how many items of treatment you had to do to make that kind of money. It was called target gross income. And then dentists would find ways of taking shortcuts and doing it in less time and make a wee bit more money and then the government would cut the fees so they could keep the amount paid to the dentist about the same and then dentists would find another shortcut and you go into this horrible treadmill where things got faster and faster to make the same salary. That was a big issue until the late 90's when the government finally broke the cycle, after a lot of pressure from the dental profession.

So getting back on topic, a phobic patient was just a nightmare in that situation. If you're paid £x because the government thinks it's gonna take ten minutes to do a filling… then it takes you ten minutes to get a phobic patient's jacket off and get them on to the dental chair then maybe twenty minutes to let you give them local anaesthetic, well you're not going to be making such a patient welcome in the surgery, are you?

So that was a big problem and one of the ways the NHS dealt with it has increased provision for special care patients was having a lot more dentists who are paid a salary, so it doesn't matter so much how fast they work.

They have a bit more time available to spend with phobic patients so that takes some of the pressure off. The idea is that the general practices will refer patients into that service so ideally they would have a routine checkup at their family dentist and if they need any intervention they can go into salary clinic and get it done and then go back for check-ups and general maintenance.

There of course are some folks who are too scared to even get check-ups at a regular dentist so they can register with the salaried service. And that seems to work reasonably well.

Of course, there still are some pressures about the number of patients you see.. if one of my dentists would see two patients a day, I would be wanting to find out why. So the salaried service generally works a wee bit better for phobics. But it's an expensive service.

Can you tell me what exactly dentistry for special needs is? What are special needs?

It's a very broad definition, so you it would include anyone with a medical or psychiatric or physical problem that would stop them from going to a normal dentist.
Anybody with a learning difficulty who would be too complicated to be treated in a general dental practice or someone with a whole host of medical problems that could interfere with local anaesthetic, someone who may need a general anaesthetic from time to time.

Basically anybody who a normal general practice dentist doesn't want to treat would be special care and quite often the dentistry would be very straight forward, but actually getting to do that on that patient was the complicated part.

You always had to have good relationship with the local medical GPs, hospital specialists etc, it was good to have a little network so that if one of my patients was going to the hospital to have a leg operation then I could jump into the theatre as well to do some dentistry when they were asleep so that way they wouldn't have to get multiple general anaesthetics. Getting to know the secretaries of most of the surgical consultants was really useful too.

It takes a wee bit of time and effort to set those kinds of networks up and to make contact with the right people to get things working smoothly, so as I said the dentistry was easy, it was the background that was more complicated in that field and I enjoyed that.

What are some special skills a dentist for special needs needs?

You have to be able to establish rapport very quickly with a lot of different people. You go into somebody's house maybe, so you have to be able to be accepted quickly. You're a fairly threatening person as a dentist, people are not generally comfortable with you. Even if they're not phobics, they're generally not big fans about dentistry and you are literally invading their personal space.

When you're coming into their home and you're bringing a lot of stuff with you, so you have to put people quickly at ease with you, you have to be able to communicate well with a lot of different people with different perceptions and different communication skills. You have to be able to keep things understandable for who you're dealing with and at the same time not go talking down to someone, that would really annoy them.

You have to have a pretty good idea of different medical conditions and how they relate to dentistry and knowledge about different drugs and how they're related to dentistry, you have to have good networking skills because as I said you have to get reasonable working relationships the way that I did with other medical professionals.

You got to be able to drive! I had two post graduate trainees that couldn't drive, it was an absolute nightmare! You have to have a good sense of direction, you have to be able to find people! (laughs). What else do you have to do? You have to be professionally flexible. Because sometimes the best treatment is what someone can't cope with. So you have to be able to accept the fact that in some situations you're not going to be able to do the very best dentistry that you can for a patient. You may look at somebody and think oh yeah, they could have four root canals, four crowns, sorted. But there's no way you could ever do that for this patient so you're going to have to consider an alternative and maybe a less "ideal" form of treatment and you have to be prepared to do that and some dentists find that very difficult.

As undergraduates you are taught to do things at a very very high standard all the time and not being able to do that can be quite difficult. And also you have to keep very good

notes because you have to justify what you haven't done. And sometimes you just have to accept the fact that maybe you just have to not do anything.
Dentists are doers, they want to do something but you may see someone who's got a couple of decayed teeth but they're very frail and very unto-operative maybe due to dementia, so if you're going to treat them, it's going to have to be under general anaesthetic to get the treatment done and they may not survive that general anaesthetic, so how are you going to do it? So that's difficult.

You have to be pretty patient. Because they're kind of trying your patience sometimes. Especially phobic patients; you might think "this is very easy, you're in a lot of pain, I'm not gonna hurt you, I can get you out of pain in 30 seconds but you won't let me" and that can be really trying your patience.

But if you lose your patience with the patient, that's going to mess things up completely, so you have to remain as calm as you can. You just have to be happy to go at their pace but sometimes you just want to go home (sighs).

You know, you fitted the person in, you know they're in pain and you've got other things to do, you've maybe got two or three patients in your waiting room and it's going to be a very quick and easy and painless thing to do to get them out of pain but they're not going to let you do it and that's a challenge. But again you just have to get them allow you to do it so you need a lot of patience.

How do you do that?

I don't know. (laughs) I go home and shout at my wife (I don't really!). I shout at my dogs (laughs). Poor dogs. I don't know, I can be extraordinary patient when I'm working and not when I'm not. I had the same dental nurse for about twenty years and she used to think it was ridiculous the things I would put up with. I would be prepared to do almost anything to get somebody's treatment done. I had one wee nervous girl and we finished up with me singing Abba's greatest hits to her to take her teeth out. And I made it and I got the treatment done. I wouldn't do that outside, but within the surgery, I would do almost anything to get somebody's treatment done…

I think maybe it's because I don't like to lose. If I don't get the treatment done, I've lost, I can't stand it so that's maybe it, I'm quite competitive with myself. So that's what does it. What other stupid things I have done… I made a Down syndrome boy teeth like Elvis Presley's.

Really? Tell me more about it.

One of the things with Down syndrome, they have wee short conical roots on their teeth and they are quite prone to gum disease so the two things together quite often means they would lose all of their teeth quite young. So sadly for this lad, we couldn't salvage his teeth, had to be removed and he refused to get false teeth.

His mom was a lovely lady in her fifties, she was getting married again and she desperately wanted him to have some teeth for the wedding and he was like no way. And we discovered he was a huge Elvis Presley fan, he used to come in with his leather jacket with the collar turned up and used to do Elvis impressions in the surgery so I had this brain wave.

I said “Bring me some photographs of Elvis's teeth and I’ll get your teeth made the same as Elvis’s". And he did it. Then my wonderful technician David Campbell made his false teeth as close to Elvis's teeth as we could get them and he wore them for the wedding. So sometimes you have to be prepared to be a bit flexible and think out of the box to get things done. But you have to know where and when.

What else you do have to do? You have to be physically flexible and bendy. Because sometimes you have to treat someone in the most awkward position imaginable; if they’re in their bed that is ok, but if they are in a wheel chair and the wheel chair is specially adapted for them then you can’t move them out of the wheel chair and have just got to try to get around it as best you can.

Physically the most demanding thing I have ever done was four crowns on a lady with pretty advanced multiple sclerosis, who was in a special wheel chair which we had to leave her in, it took about three hours and by the time I got home I could barely straighten up.

I’ve been lucky I’ve been blessed my whole career with having no back problems, most dentists have back issues but I seemed to be immune to it.

What I did notice over time was that my two shoulders had moved around, my right shoulder was way down here and my left was way up here, but since I’ve retired they’ve straightened up again. So that was good. And my double-chin has gone away! So there are some benefits to retirement (laughs).

The other thing you would need is a really good assistant. I was blessed with some really good nurses, Lesley, Karen**,** Eileen**,** Carrie Anne, they were all superb. And you need that. It’s not just to help with the dentistry, you need the assistant to be on board and working with you to make sure you’re working as a team to the same objective.

I have spent some time thinking about language, people can say the wrong thing and it can have a profound effect so you have to watch what you say.

For instance, I never ever tell people something wouldn’t hurt, if I knew it was going to, because you must not break that trust.

If something is going to hurt you have to tell the patient first, but you have to do it in ways that it doesn’t make it a big deal. So you’d say “You’re about to feel a sharp scratch, you’ll feel a wee bit of pressure, this will be a little bit uncomfortable. It’s like being bitten by a dog or a cat or a pet. Your puppy may have bitten you some time”, a wee bit like

that. Say “It’s a bit squeezy. I’ll be pushing here. There will be some horrible noises and that’s ok.

You have to tell people the truth but you don’t have to tell the absolute unvarnished truth. On the other hand outright lying to patients is never going to get you anywhere.

You need back-up. These days there is a lot more formal training for special care, thanks to a lot of work from the British Society for Disability and Oral Health amongst others, Special Care Dentistry is now recognised as a speciality by the General Dental Council so we have formal training pathways. People can train to work as a specialist and again that helps a lot.

Because again, when I was starting out there was no formal training at all. I was lucky I had a chap called Bob Walker who was a sort of mentor for me in Ayrshire when I started in the special care service. He was put in charge of it because he had a keen interest, but again no formal training. So he was a sort of mentor for myself and a good friend Anne Poynter, another dentist who started in Special Care at the same time as me and we kind of made it up as we went along with help from Bob. There were no courses you could go on but that has all improved now.

There is a much more developed post graduate training system in general then when I qualified. Looking back on it, on my first job I had qualified as a dentist; let’s say it was on a Friday and on Monday morning I was in a surgery on my own 20 miles from the practice and the other dentists there so things have improved.

<u>You mentioned the ability to build rapport extremely quickly with a lot of different kinds of people. How do you do that?</u>

I don’t know for sure, it comes with practice to a certain extent. You find something that you can talk about. I’m lucky I was always interested in history; so with a lot of older patients, I ask about something that had happened to them when they were young, for instance, I found that one guy had been a gunner on HMS Rodney and so we had a long discussion about HMS Rodney and because I’d remembered a fair bit about it, so I had a discussion with him about it.

Another guy had been in the army in Italy so I was able to talk about the Italian campaigns in the war so something like that, somebody else maybe has got a dog or a cat or they’ve got a hobby, the chap with Elvis, find something.

You need to talk to your patient, you have to try. And even if it’s ABBA. I don’t know much about ABBA, but I have one of those brains that remembers loads of ridiculous, trivial things, I’m really good at trivia questions and stuff like that, so I can remember things and that usually gets me some hook to get into and I can sort of bluff my way through on lots of different subjects.

I don't watch much TV but I know roughly what's going on in the most of the soaps, I don't go to films much but I kinda keep up to date of what's happening in the cinema so I can find something to talk to patients about and that's what you're going to do, find a common ground and explore it.

But YOU have to go to their common ground. You can't get expect them to come to you. If you know somebody's interested in something, then go there.

Part of it is trying to be as different from other dentists as possible.

I know I'm quite a big person so if I come in to your house or into the surgery, then, you know, I can be a bit overbearing so I try not be, I smile a lot, make eye contact, work on my body language.

You know how people relate more to you if you tend to copy what another person is doing with their body language, and you find yourself to do a lot of that unconsciously.

After I took lectures on behaviour science I was like mmm, I'll try to do more of that. I read up as much about behaviour sciences as I can and try to implement it, the trouble is that a lot of it is kind of contradictory**,** but trying to find what works for you is the thing.

My thing that works for me usually is making lots of daft jokes. I have a huge repertoire of appalling jokes and pull them one out every now and then and that's what works for me. However, some people don't like that and I have found one or two patients told me stop the jokes and be serious please, so you have to again switch but a lot of times humour works well.

Another thing that worked well for me especially with phobic patients is to be different. They have usually been through several *normal* dentists and it didn't work with them. So you have to be the *abnormal* dentist.

Usually I introduce myself to people as a strange kind of dentist. Unfortunately due to cross infection control nowadays you have to wear scrubs in surgery but I didn't ever use to.

I would wear a polo shirt and a pair of trousers, never wore a white coat. Never. I don't wear a face mask when I'm working. I don't care about catching the odd cold, so I don't wear a face mask.

I do wear magnifying lupes (sort of like magnifying glasses) because I'm old but I don't wear a face mask so I can still talk to people and they can see my face. Other dentists will get the patients in and get them in the chair quickly and sit them down but I had an ordinary chair in my surgery so sat them in the ordinary chair and chat with them first. Make jokes but don't make fun of them.

The other thing that helps massively with phobic patients is they seem to think that they're the only person in the world to have this problem, so telling them, "You're the fourteenth person like this I've seen this week" then that can be a big help.

A lot of people think they will be seen as stupid and a nuisance. I'm quite lucky, I'm phobic about fish, so my usual line is "Being afraid of the dentist is quite sensible, because we can do bad things to you, but I'm scared of fish! How stupid is that?"

And they'll laugh with you, you see? I know everyone is scared of something. The ones who aren't scared of anything just haven't found it yet. But yeah, that works.

Usually if can I get people laughing at me then they're not so scared of me. One of my post-graduate students, who certainly wasn't scared of fish, started to tell patients she was scared of something else, I think was it bugs or something? She had heard my fish routine and she went aaah, yeah, I'll use that. So yeah, she stole it she said she was scared of something.

How does a homebound patient get help, could you describe the process of the journey?

Yes, they would start with their health visitor or the medical GP, making a referral, we had some health visitors who were very proactive, they would go out of their way to ask the patients whether they had any dental problems.

We started a thing in Scotland few years ago called Caring for Smiles, that was for training the people who were caring for the elderly to recognise dental problems, which was then integrated with a protocol of how to get help and we formalised that and I helped to develop it in Ayrshire with a lady called Maura Edwards who was a Consultant in Public Dental Health in Ayrshire and it became adopted by the Scottish government, so basically care workers for the elderly would have a quick assessment sheet: Do they have teeth yes or no, did they have a check-up in three years, are they able eat, can look after their teeth themselves and some of the yes in the questionnaire would trigger a referral.

But prior to this, the idea that the dentist could come out to the house was amazing to patients, so it would usually have to be health visitors, district nurses, doctors who would make a referral.

Then the reception staff at my clinic would contact the patient to see if they were housebound. If they could come to the surgery it's better, but if they couldn't, if they for some reason couldn't get out, then they would send a dentist who could come and see them.

Usually me. And we had a full dental clinic kit you could take with you, fully portable, came in a box about so big and so you had dental motors, the suction, a scaler and lights. So you can do most dentistry in somebody's house. I don't like it but it's doable.

I have seen this on the IDS this year, those luggage-looking boxes…

Yes, it's basically a big box, a very expensive big box, when we got them for the Highlands, it was about 6,000 Pounds each. It's got a little air compressor, so you can plug it in the patient's house and you can compress the air in the 3 in 1 syringe and a high speed dental hand piece and stuff, it's got a little suction motor so you can aspirate, vacuum up the water etc.

When doing an extraction in someone's house you had to be awfully careful not to break the tooth because it's a nightmare trying to get bits of a tooth out in someone's house. My worst experience was trying to take a tooth out when it literally exploded in my face and I had bits in my eyes and I got the most terrific conjunctivitis.

By the time I got back to base my eyes were swollen shut and my boss looked at me and was like "Hospital NOW!" (laughs). So that was fun, I was sitting for three days in a darkened room with sunglasses on and that was bad enough, but breaking a tooth in somebody's house was a nightmare.

You can get it out after a while but it's a struggle if you don't have the facilities no proper suction, no motors and so on.

Taking a tooth out at home was an absolute last resort but again sometimes you just had to go for it. In NHHighland we had a proper protocol to put it all down paper first so it could be fully justified but it's a worrying thing to do in someone's home.
Probably the most risky thing is sedating somebody at home in the community and that's terrifying. But again, sometimes you just have to do it. If they're too bad with Alzheimer's and very stressed by being taken out or are too frail for a long journey or whatever then you have to do it at their home and they're really frail and you have to sedate them and they're not healthy and so on…

Alzheimer's patients can have unusual reactions to sedation drugs anyway and you could be working somewhere like here in the Highlands you could be twenty miles or more away from help so that is probably the scariest thing.

How does it work with consent in such cases?

If you as an appropriately trained professional deem someone to be unable to give or withhold their consent for treatment than you can act in their best interest under the Adults With Incapacity Act and do the what treatment you decide would be in their best interest.

You generally discuss this with the relatives before you do it, you don't just do it and you do the minimum amount of treatment to solve the problem.

The normal protocol is to give the patient usually some Midazolam mixed with a coca-cola or orange juice and then wait until it takes effect, then do the treatment and have

someone available to sit with them for a few hours afterwards. You also have to make sure you stay in the house for one hour after the treatment's done, to make sure the worst of the Midazolam effects are over and then leave them with the carer.

If they're in a nursing home obviously there's carers there, but if they're in their own home, then you need to establish of there is somebody appropriate to care for them after you leave.

You have to have sedation skills so that you can work out an appropriate dose and are confident to do it, you have to have IV skills, if you have to reverse the sedation you have to be confident in a way to give them an antagonist and to reverse the Midazolam and you have to have the skills to do the domiciliary treatment to do the treatment in their house, so there's not too many dentists who would be qualified to do that safely.
And even the ones who are qualified to do that safely hate it. It's the scariest thing you can ever do. So I don't do that very often. I don't do that at all now, I'm retired, but I didn't do it very often and I would never volunteer to do it but sometimes you have to do that.

<u>You mentioned 10% of your patients being phobic, that doesn't sound too much.</u>

It's not that much. Couple of clients a week for an area like this once the sedation service was properly established.

I wasn't working full time as a clinician here, part time manager. But when I was a full time as a clinician we had maybe two or three sessions out of ten were phobic but not all of those patients sent in were phobic, it was normal special care patients who could come into the clinics.

I think there are probably very different numbers of phobics depending on the local population and you can't generalise what kind of person is going to be a dental phobic.

They come in all shapes and sizes and parts of the community. I had one guy who was an ex paratrooper in the Falklands war and happily jumped out of the airplane in the dark, two thousand feet up with a handkerchief tied to his shoulders; no problem, but get a tooth filled? No chance.

So there's no logic to it, you can't predict it. You can see great big men in tears sitting in the waiting room and also there will be four year old kids who just come in and happily get the treatment done, you can't generalise.

What seems to happen is that there's been an underlying tendency towards dental phobia and then there will be some extrinsic factor come along and really reinforce it, e.g. a dentist who fails to get a tooth numb and won't stop when they're told to stop or something like that happens and then it becomes a really immense issue and that's when you really will have to work to overcome it. We're back to the issue of losing trust again aren't we?

And fair play to the patients too, a lot of phobic patients, they decide for their own reasons to do something about it. I think dental phobics are tremendously brave because they're really really scared of something and they just face up to that and do it.

So OK, they can get help from drugs, get help from a friendly dentist, but at the end of the day they are the ones who ended up doing it and they're facing their fear head on to do it and I have a huge respect for people doing that.

I think there's a lot of phobics are very hard on themselves, thinking they're being stupid, especially if they're males, they think it's not that male being so scared and it's stupid, but it's not.

They forget that even going to the dentist, getting sedated, or getting knocked out and getting the treatment done they're still getting over their fears. I have a tremendous amount of respect for them. They don't necessarily see it that way, but I think it's quite humbling sometimes if someone is facing up to something that they're absolutely terrified of and they'll do it, because I couldn't. Probably!

Sometimes there's an external factor like they're getting married, or they get a new girlfriend or a new boyfriend, that's the pressure to do it but they still have gone on and conquered a major fear.

I know there are cases when an examination and the treatment are both under general anesthetic in one session, how does it work with the consent in those cases?

Generally a lot of those patients wouldn't be able to give consent themselves, so it would be done within the Adults with Incapacity act.

If it's a child it would be the parents we get consent from. You have to remember though, that in the UK, children can still give or withhold their consent if I as the professional think that they have the capacity to do that!

You have to have a discussion with the carers/parents beforehand to say we don't know what we're gonna be doing here and there may well be extractions.

It's nice if you can prepare them that there's going to be a lot of extractions if you think there are going to be but sometimes you just don't know. You have to be kind of aggressive with your treatment planning with general anaesthetic too, because it can be very dangerous if you have to get back in quickly to do another one.

You want to do everything you possibly can within one anaesthetic and not have repeat it in a hurry. So if it's a close thing between an extraction and a filling, you'd take the tooth out.

You almost never do a root canal. Because the chances of it going wrong are too high. And you'd almost never do a crown because you would have to do a second general

anesthetic to fit the crown. Although these days with the CAD CAM you maybe would be able to do it in one visit, but we didn't have one. Another problem was taking x-rays of teeth, it was very difficult, almost impossible to take x-rays.

Nowadays with the digital stuff it's a lot easier, got a laptop and a sensor and you can do it, which is great.

The treatment for the patient is going to have to be more aggressive and less conservative so they're going to have more extractions than they would get if they weren't asleep, so that's another discussion for a phobic patient who thinks if "I could just be knocked out and have everything done that would be great" and theoretically yeah it might be, but there's two things, one is the chance you may not survive the anaesthetic and two you're going to have more treatment, you're gonna lose teeth that could be saved.

If that's your front two teeth, you'd need say, a couple of root canals and a couple of crowns to fix them, but if you're going to get knocked out, you're gonna lose them. And for a lot of people that might be the persuader to make them try sedation instead.

Sedations is a phenomenally good technique. In eight years working in NHSHighland we saw four patients for IV sedation every week and we only sent three of them in that time for general anaesthetic.

Why?

There are patients that IV just didn't work for.

That means they are still not cooperative?

That means they are still not cooperating enough even with IV sedation. The only way to carry out treatment for them was general anaesthetic. Because different people react to drugs slightly differently so even with a lot of Midazolam some people are just not sedated enough or are not cooperative enough. Or some wouldn't let you put the IV line in, that happens occasionally. We can usually get around that with a wee premed though.

You have to be prepared to stop. It's not a universal thing, it's not going to work for every single person but it works for more than 99% of people.

Is there any way to predict whether this patient will be able to get the treatment done under IV sedation?

If they have had it before and it worked it will probably work again, but if they haven't had it before (and a lot of times they have never had it), then no, not really. You can get a feeling sometimes about how nervous they are, but it doesn't always follow.

You can use pre-treatment questionnaires and stuff, sort of screening questionnaires but they don't appear to be hugely reliable, they can predict whether you're gonna need to use IV or inhalation or if it would be reasonable to do it in another way but they don't seem to give you any indication of whether it's going to work.

If someone's got a long history of benzodiazepam use, then chances are that it's not going to work, they're going be so used to it and quite a lot of times you don't know that, they wouldn't tell you, they may tell you they have taken recreational drugs but you have no idea how long they have been doing it before. You can't just tell… but you have to be prepared it's not gonna work.

Which is another problem, if I were to do IV sedation in practice and you're charging for it then to abandon things, you have to get some money for the amount of time you've spent but the patient may not be too happy to drop few hundred pounds with not having the treatment done, they'd see it as just getting a wee drop of Midazolam. So again as a salary service that's an advantage that you just call it quits and say the patient is not going to pay for it.

A dental practice costs a lot of money to run and if you're not productive it still costs few hundred pounds an hour to run it so I can manage it.

I had no idea that IV sedation possibly can't work for someone because if you google it, it's like a substitute for GA.

It is, for the most people. 99%. Easily. But there is always 1% that it doesn't work on.

There are sometimes ways around it, if you do the polypharmacy thing that we said as in America, a few different drugs will help where with just one drug doesn't work.

I had one patient I was seeing with my late colleague, Jamie, who was getting a lot of cosmetic work done. Normally the dose of Midazolam is between 5 to 10 mg for most people and that's enough.

This girl would be roundabout a size six maybe, six stones dripping wet, she came in and she had 45 mg of Midazolam and she was sat up in the chair chatting away as if nothing had happened. Nothing! She had a wee bit of amnesia. That was it. She was singing, dancing, chatting away and having a lovely time, but she wasn't the slightest bit sedated. So what we had to do with her was bring her back again, giving her an oral pre-med to optimize it, a slightly different drug and then a bigger initial dose than normal and she was sedated for about half an hour but that was enough for me to give her local anaesthetic.

Because all she was worried about was the local anaesthetic so when she was numb she was fine. But she was a real challenge and that was a purely cosmetic case, that was just some veneers and cad cam crowns and stuff that wasn't really life or death things, she was just she didn't like the anaesthetic so that was fine.

I've had another patient, a guy who was a Russian bodybuilder. To take his blood pressure we had to borrow a special cuff from the doctor's surgery, his biceps were bigger than my thighs and I'm thinking "Oh god, do we have enough Midazolam in the building to sedate this chap?" And he had two milligrams and he goes "Wow, that's really good vodka" (laughs). Off his face.

You just can't predict the patient's response, you have to give the drug slowly and carefully.

He was really funny though, he was totally spaced out on about two milligrams, knew nothing about anything. So that can be entertaining too.

Another times people remember nothing about what happened, generally they remember feelings but they don't remember details. So I tell people you will remember afterwards that you felt pretty good. You remember it was all easy and all went really well but you don't remember the details and they go sure and then a couple of days later they say like that was like great but I don't remember a thing. Buy they're talking to you all the way through and you say "Remember you told me about your holiday in Spain last year?". No! And they're looking really freaked out as they don't remember they said that. How did you know that!

That was one of the fun things we did with Jamie; he did these lovely cosmetic cases. Jamie's thing was he loved to do the big reveal at the end. The patient would get all the treatment done, obviously using the CAD CAM system so it was all done in one visit.

After it was all finished, he would get a mirror to show them the work and they say "Awwww, it's wonderful Jamie, you're a genius, Jamie, I love you!" And five minutes later they'd forget they had seen it so they would say: "Can I see it? Can I see it?" So he showed them and they go again "Aaaawwwww, that's wonderful, you're such a genius!" And then five minutes later they'd say "Can I see it? Can I see it?" And he was like "this is such a boost to my ego". That was a good laugh. I really miss working with Jamie.

Other times a patient would say to me "How the hell did I get home? I don't remember anything between coming in to the surgery and going home".

Another story, a patient in Glasgow as I just started doing some IV in practice. There occasionally is a thing called anterograde amnesia, the amnesia kicks in from before they had the Midazolam.

The story in this case was the lady who was the patient lived out in one of the suburbs of Glasgow, the practice was in the city centre and her husband worked in the city centre. The plan was that she would drive in from the suburbs and park the car in one of the car parks.

Come in, have the treatment done, her husband would finish up work, pick her up and bring her home. All worked great, got the treatment done fine, her husband come to pick her up and said,
“Where’s the car?”
“What car?”
“Where did you park the car?”
No idea. Couldn’t remember. She had anterograde amnesia and no idea where her car was parked, it was somewhere in Glasgow. Big city. What the hell are we gonna do here? So my receptionist was really clever, she thought about it and “aha, have you got a ticket from the car park?” Yes. It didn’t tell where the car park was but it had a serial number on it so she phoned Glasgow corporation council and told them “We’ve got a ticket from a car park with this serial number, can you possibly tell us where the car park is?” They were able to narrow it down to one multi-story car park so they just had to get a taxi and drive there to get it. They found it fairly quickly!

So since then you advise your patients to better come in with someone?

Yeah, I would tell them to have an escort person. One of the reasons to ask them to have an escort bring them in is to actually make sure that they have an escort because it’s not been the first time that someone has been sedated and then you phone the escort to come in and get them and there is nobody there and you’re left with a sedated patient and no escort. And that can be interesting.

So no, now I usually insist the escort has to be physically come in the clinic so that we can see them before they get the sedation. Because I’ve trusted a few people who said my escort will come and pick me up afterwards and then they don’t show, so what do you do? Take them home with me? “Hi Janice, we have someone extra for dinner today?” (laughs).

The other one is the person who has had the sedation and then is the driver… We had that too,
“You’ve got to drive her home.”
“No I can’t drive, he is the driver!”
“How did you plan to go home?”
“He will drive…”
No, he won’t. You’ll take a taxi.

If you have a patient who you can’t help, what would be the reason for that?

Probably because they wouldn’t let me, number one reason being if I have not managed to make the connection with them. So they either decide they don’t like me or they won’t let me help them basically. Which would be my fault because I have not managed to make the connection. It’s generally because there has been a failure of rapport between me and the patient and because generally they’d let me. If they let me help them, I will be

able to help, but if I just can't do anything with them at all and they won't cooperate with me then that's a communication failure basically. It doesn't happen often.

What would you like to let your you at the beginning of your career know if you had the chance to?

I don't know. Because there are a lot of things you learn the hard way and there is a lot to learn. My old boss, Cathy always said that the best feedback was negative feedback.

Back to the question… probably don't think you can be everybody's dentist. If you have a general practice especially. You can't please everybody. And trying to please people sometimes is not going to help. Sometimes you have to be tough and say no, this is not gonna work, I can't do this. I had a terrible habit my first few years in practice, trying to do things that just weren't possible. Looking back, if you get a patient who is never going to be satisfied with dentistry then trying to satisfy them is going to be impossible, so it's much better to say no, this is not gonna happen.

Some things you learn the hard way but some things I wished I would have known a wee bit earlier. I wished I had access to sedation a bit earlier. Trying to get treatment done just by talking to people was probably good practice but it's just a lot more stressful than just giving them a wee bit inhalation sedation or an IV.
What else? Some investments I shouldn't have made (laughs). One place I shouldn't have gone to work in because it didn't suit me.

What do you think are the challenges in dentistry nowadays?

Nowadays people's expectations are at a higher level. We have a cohort of patients who have had pretty much all the restorative work done. When they get to my age, they've had a lot of very complicated dentistry done.

They're getting older, the dentistry is failing but they don't expect to lose their teeth. The generation before me no problem, take teeth out, get plastic ones. Happy with that. My generation, as they get older and older, going to nursing homes, their home care suffers, they have exquisite dentistry that's been done over years and that's gotta be maintained and the maintaining is gonna be very difficult and it's a real challenge for the profession.

Another one is coming from those people with implants going to nursing home care and their implants still have to be maintained and that's gonna be a challenge for the future as well.

For the younger generation too there's always nicer new materials coming out, the pace of development has changed as well, so you have to spend more time keeping up to date with what is going on.

But that's probably easier now because of the internet; so you can keep up to date with what's going on much easier than you could twenty or thirty years ago. Then you had to go to a course somewhere to learn something.

One of the most useful things that I did was going over to Florida for a dental course over the weekend and A) it was probably the most exhausting thing I have done and B) it taught me so many new things within one weekend. This was way earlier than internet and stuff.

E-Mail was around but that was about it. And I had the most horrendous jet-lag, going to Florida, coming back, working from the Monday to the Friday bad idea. Just about got used to sleeping there and then coming back immediately.

But I picked up a lot of stuff so it was worth it I suppose.

Keeping up to date with changes in some ways is easier now but there's more to keep up with.

But I think the big one is the older generation expecting to be able to maintain their dentition and fail to be able to do that and implants aren't necessarily the solution when they get older as well.

Is there anything you would like nervous patients to know?

We are trying to help. At the end of the day it's your problem, we're trying to fix it and we're trying our best to help you. We're not here to hurt you. Dentists don't wake up in the morning saying "Yeah! Maybe I can hurt someone today." We don't think like that. Most of us do dentistry because we wanted to do good things and help people save teeth. We don't particularly enjoy hurting people, or making people feel bad. Really, I don't know many dentist telling their patients off because their teeth are bad. I never met a dentist that did, if I did I'd take action to stop them.

If someone comes with a mouth of cavities I wouldn't think "What a mess, how the hell did you get it into that state?" I'd be thinking "How am I going to sort this?" There might be a few dentists thinking "Yeah, that's my new BMW sorted!"

But generally it's about how am I going to fix this. We don't care how you got like that, we want to know how to fix it. We don't think you're stupid, we don't see it as being your fault particularly, we just want to fix it and that's really what gets most dentists up in the morning, it's to fix things. I'm retired now so I wanna fix stuff at home, my wife Janice will tell you.

People with phobia seem to be specially sure they were going to get told off, that dentists are gonna be angry with them. Not in my experience. Most of us just want to go and do stuff.

But where does this come from?

I don't know. It must have happened to get out here, but it's like dry socket. There's not that many cases of dry socket but it seems to be an utterly terrifying thing! People are terrified to have them but it doesn't happen very often and generally you need to be very unlucky to get one.

But this fear of being told off, it just seems to be going the same way, it has entered the public perception for some reason. Maybe dentists used to be a bit like that but I don't know, nowadays they just aren't.

Certainly when I was a kid I almost never brushed my teeth, I also ate a load of crap, I'm amazed I have any teeth left! I don't remember a dentist ever scolding me for my teeth not be clean enough.

I had loads of fillings, and he used to just get on with it. I think he was getting his new Rolls Royce paid for. Yeah, my dentist had a Rolls Royce.
And I think I chipped in towards it (laughs).

Maybe - you asked me why I became a dentist. My mother was a terrible dental phobic. My mother had false teeth from about age twenty. And she was such a dental phobic that she wouldn't come into the clinic for me to make her false teeth. I had to bring the stuff home and do it in her house.
When I was about eight or nine I had to get a tooth taken out. And my mother was so afraid of taking me to the dentist, that the dentist wouldn't let her drive us home because she was shaking so much due to ME having a tooth out. I was fine. So he put us into his Rolls Royce and he drove us home.

So maybe that's where it comes from. And I never did anything with my mother's phobia, she was just beyond help (laughs).

When I opened a practice, she helped me to put the wallpaper up on it and decorate it, but that was before the surgery went in, once the surgery was installed, she wouldn't go back into the room.

I wanted to show her, "Look at my new surgery, it's lovely" and she was "No!". Wouldn't come in. And this is someone with no teeth. Who had no teeth for forty years and she wouldn't come into the surgery. But yes, there are phobics like that.

My mother in law was just about as bad, she used to tell me stories about putting mustard powder in her teeth to kill the nerves of them so she wouldn't have toothache? Really?! What do you think a dentist is gonna do to you that is worse than that? That, yeah, maybe that's how I became interested in dental phobics, I seem to attract them (laughs).

Is there anything you would like young dentists to know or students?

I've spend a lot of time training young dentist. I was a senior adviser for NHS Education Scotland, so I think I've passed on as much as I could, the training nowadays is much, much better in terms of what to do with special care patients and phobics and sedation.

And so yeah, be nice to your patients and they will be nice to you, I think that's the main one. I know of some dentists who were the most appalling clinicians, dreadful dentists, whose patients adored them. Luckily they are not in the register anymore!

Patients really can't tell how good or bad the dentist is and again they just know whether they are a nice person or not.

The advice I was given by the Dean of Dentistry at Glasgow when I was a student: if your false teeth don't fall out; your injections don't hurt and you are nice to your patients, you'll do fine. That was Jimmy Ireland, a lovely man, he was a very wise chap and he kept saying that.

What is it you like about working with children?

I'm a big child myself, that's probably why. And I think it's important, if you do a good job with a child and get them used to dentistry from an early age, you've got a cooperative happy patient for life. If you've messed up at that stage, you've messed them up for life. That's a big responsibility but I think I can do it and make it a positive experience for them. So I think it's important to do it right and I used to think I was being good at doing it and I like kids, I enjoy working with children because I'm a big kid myself. I played PlayStations, I used to build models, I watched children's cartoons, I tried to keep up with them.

What was your favourite part of dentistry?

The thing I enjoyed the most was making dentures and I was really good at it. I also liked taking teeth out too, I probably shouldn't mention that (laughs). I enjoyed the challenge of it, physically challenging to do it right and to get a good result.
That is the physical dentistry stuff I enjoyed doing the most, but the thing I got the most pleasure out of was; if someone was a real phobic and I got them through that and then when we're finished and they were really pleased about themselves and felt good about it.

And what I didn't enjoy, that is the next question, isn't it? I hate root canals. I can't imagine spending my whole life doing endodontics. I'm rubbish at it, I know I'm rubbish at it and I tell everybody I'm rubbish at it. Don't like orthodontics much either. I like to see the results. I like when an orthodontists sends me before and after pictures, that's great. But don't ask me to move around a tooth.

If you are at a party, meeting some people, and they ask you what do you do for living and you say you're a dentist…

I don't. I work in the health service.

Really?

Yep.

Why?!

Because I work in the health service. I'm not defined by what I do for a living. I'm now retired, that's easy. I was at a party on Sunday and someone asked me and I did tell them what I did. But that was ok because he was a doctor and he was the same, he worked in the health service (laughs). You don't tell people this kind of stuff when you get asked.

When I was a dental student I used to tell people I was a dental student and they would go "Oh, really?" and start wanting to tell me about all their problems not just dental ones!!! My son is a doctor, we say we work in the health service.

Maybe it's a self-defence thing or we just want to put ourselves down. But I know most doctors and acquaintances that's what they would say, they work in the health service.

One thing is good that it stopped. Because I'm a big child I still read children's comics occasionally. When I was growing up the dentist in them was always a horrible figure, catching children on the street pulling their teeth, something like that. And that seems to not happening anymore thank goodness. There was always a negative connotation about this but the comics seem to have gotten wiser and not doing this anymore. Thank goodness.