

THE PROBLEM OF RECOGNITION

WHY IS IT that gums are low on the list of dental priorities? The reasons are partly historical and date back to the bonanza years of NHS dentistry – 1948–1968 – the years of drill and fill before the advent of a preventive philosophy. There was little understanding of prevention in restorative care (fillings) and less about periodontology (gum disease). The crown and bridge explosion of the 1970s, together with increasing consumer awareness and expectations, led to more patients keeping their teeth later in life. By the 1980s teeth that were eventually lost in older groups of adults were more affected by gum disease than caries (decay). NHS gum treatment has always been relatively poorly rewarded in an item of service method of remuneration. This is because the Department of Health finds it difficult to quantify the time required for the necessary interaction to explain, motivate, encourage and if necessary gently admonish non-compliance. No other field of dentistry requires such a high level of communication skills or joint endeavours by both practitioner and patient. At one end of the spectrum is the practitioner who spends time talking and explaining oral hygiene procedures to his patients and employs a dental hygienist; at the other is the totally non-communicative dentist who does a 5-minute scaling while a local anaesthetic is taking effect prior to doing fillings.

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Lawyers acting for clients who allege a failure to diagnose and record periodontal disease will always hear the complaint expressed as: ‘Why wasn’t I told?’

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2	2	4

Fig. 2. Record of a base periodontal examination guide. The example shows that the patient has pocketing over 5 mm in the upper premolar region and the lower right molar area. The upper front teeth have 1–2 mm pocketing in at least one area.