Guide for FCDSHK Intermediate Examination in The Specialty of Family Dentistry

It is expected that a specialist in Family Dentistry (FD) denotes a practitioner who can practice general dental surgery to a high standard and in safety, treat patients with care and sensitivity, and be the leader of a dental team which is motivated to be efficient in all routine dental practice procedures. FD specialist should also be able to deal competently with emergency situations, and be continuing students who can recall and utilize, to the advantage of their patients, the knowledge and expertise acquired from further experience, regular study and attendance at meetings with clinical and scientific content and at postgraduate courses’.

The examination will test the candidates’ ability to achieve the level of ability both as a clinician and a practice manager.

The challenge for candidates is not just that of dusting off old textbooks and reactivating old study techniques. The examination process should be a reassessment of one’s individual skills and philosophies of care, an informed analysis of treatment protocols and attitudes, and a broadening of ones knowledge in all aspects of dental practice.

Motivation towards updating and improving clinical skills and an enthusiasm for continuing postgraduate education are prerequisites for the FD Intermediate Exam candidate. An understanding spouse and/or supportive friends can be equally important in the maintenance of sanity and a sense of humor when pressures mount.

Studying for FD requires hard work, self-discipline and commitment from all participants. At times it will be frustrating, confidence-sapping and a major impingement on one’s social life, but ultimately it should prove a satisfying and worthwhile challenge with the achievement of the fellowship providing a valuable reward for all the effort.
Answering Techniques

There are only 3-4 frameworks around which questions can be answered. By knowing these frameworks and applying them, provided one has a minimum knowledge, a pass mark can be obtained in a close marking system. More than one framework can be applied to a question.

FRAMEWORK

1. **Management.** “Management *does not* equal treatment”. Management equals:

   - History - name, age, occupation.
   - Examination.
   - Provisional Diagnosis.
   - Investigation.
   - Diagnosis.
   - Treatment.
   - Outcome.
   - Follow-up.

   Remember “**Common things occur commonly**” so place common things first in lists of differential diagnoses.

   Also start with simple non-invasive investigations; eg:

   Radiographs - Start with plain x-rays and work through to CBCT, MRI, etc.

   The management framework is most useful for questions which are phrased:

   - How would you manage......?
   - How would you assess........?
   - How would you establish.....?
   - How would you investigate..?
   - Discuss the diagnosis of......?

2. **The Surgical Sieve.** The surgical sieve is a way of classifying diseases as an aide memoir. It is an effective list to flick through mentally to ensure that you have not left out any major diseases; eg.

   - Hereditary
   - Congenital
   - Traumatic
   - Infection
   - Neoplastic
   - Idiopathic
   - Degenerative
   - Autoimmune
   - Metabolic
   - Latrogenic
   - Endocrine
   - Cystic

   For those with poor memories a simple sieve encompassing 90% of conditions is 2T’s and 5I’s:
T- Tumour, trauma.
I - Infective, idiopathic, inherited, inflammatory, iatrogenic.

This framework is particularly helpful for questions such as:

- Discuss the aetiology of……………….? 
- What are the causes of……………….? 
- What are the types of……………….? 
- Discuss the diseases affecting………….? 

3. **Anatomy**. In a given question; eg. discuss tumours affecting the palate, the simplest approach may be to think of the tissues forming the normal anatomy of the area:

   - Mucosa.
   - Connective tissue.
   - Fat/muscle.
   - Bone/cartilage.
   - Blood vessels.
   - Nerves.
   - Lymph vessels.
   - Specific tissues; eg. salivary, teeth, etc.

Using the anatomy framework one can answer any “regional” question from first principles. It is most suitable for questions such as:

- Discuss tumours of/arising in………….? 
- Discuss trauma to…………………….? 
- Discuss lumps/masses in………….? 
- Discuss surgery of………….? 

Finally, remember:

a. **Definitions**. It is useful to begin an answer with a definition when appropriate; eg: in a question on jaw cysts the first sentence should define a cyst.

b. **Your examiners will have a limited stock of questions**. Read past papers for the last 10 years. See what subjects are common and therefore important and try to assess current trends.
THE LOG DIARIES
WHAT IS WANTED

The log diaries should be seen as a means to an end, and not of intrinsic value in themselves. No amount of elaborate presentation will replace a good and carefully thought out treatment plan. The purpose of log diaries is to make it easier for the examiners to judge you as a competent and caring Family Dentist. In presenting them, modesty is preferable to flamboyance. If you have special skills the examiners will find them out for themselves.

CHOOSING THE CASES

Candidates are reminded to choose their cases combination carefully; it is not prudent to have four cases which require similar treatment strategy. Multidisciplinary management is the key expectation in individual case, single disciplinary treatment of complex level would not impress examiner by any degree. Although there is no restriction on specialist referral for advanced procedures, candidates should choose cases requiring treatments appropriate to their skill level, and carry out the majority of the treatment plans on their own. Emphasis should be put on sound treatment planning based on appropriate clinical information and evidence based principles. Each case should have an expected treatment goal that candidates can achieve, or prove to the examiners that it can be achieved following the designed treatment plan.

The ideal patient is someone that you know and with whom you have already established a satisfactory dentist/patient relationship. There is nothing wrong with a friend or relative on a quid pro quo basis and this does not have to be acknowledged in the diary. It should be someone who is available, reliable, motivated to help you and with whom you feel comfortable. The most important criteria are that they should have time. It is preferable to do a routine case on a dependable patient than an ‘interesting’ case on an unknown person. Except in very exceptional circumstances, do not choose a patient to whom you cannot explain exactly the nature of the diary and the examination. If you choose a young patient give a full explanation to the parent(s).

It is an advantage if at least one case is a patient on whom you have already undertaken restorative work for several years previously and whose records and original radiographs are still available. This will enable the examiners to see work completed without the examination in mind and the validity of their judgement will be enhanced. You may need to choose no less than 10 potential cases for the preparation of log cases, as some of them may just drop out or the treatment outcome unsatisfactory.

At the first appointment carry out the following, even if you think it irrelevant at the time:

1. Take study models.
2. Take radiographs.
3. Take photographs.
4. Take or retake dental and medical history.

5. **DO NOT PICK UP A BUR UNTIL YOU ARE SURE YOU KNOW WHAT YOU’RE GOING TO DO, AND HAVE SET OUT ALL YOUR OPTIONS - UNLESS TO UNDERTAKE EMERGENCY STABILISATION TREATMENT**

6. Failures regularly occur due to candidates failing to stabilise disease processes and failing to indicate their use of an on-going system of patient monitoring, prior to start definitive treatments - if the patient is in a rush for treatment, don’t use them!

Pay particular attention to the standard of pre-operative radiographs, models and other clinical records which could not be re-captured after completion of treatment.
EXAMINERS PERSPECTIVE

Examination Aims

1. To test the skills and understanding required for an experienced general dental practitioner with the use of appropriate means of satisfactory quality (photographs, study casts, dies etc).

2. Recognize the achievement of an appropriate ‘gold’ standard of patient care.

3. Recognize a commitment to continuing professional education.

4. Provide a benchmark which indicates an appropriate standard to our patients.

Particular Points about Part II

General: It is invariably the Log Diaries that are responsible for preventing candidates passing, which is interesting since this is the part of the examination which is most controlled by the candidate. Or to put it another way, candidates usually fail themselves in the area they are most able to determine the outcome of!

Cardinal Rule for Candidates: Always read the Regulations carefully and ensure that you have complied fully with them. Do not fail yourself on a technical knockout!

What They Are Doing: Candidates will be showing skills appropriate to their clinical experience. This means identifying care in their management of the patient and their needs.

You can see that this encompasses much more than simply carrying out treatments - examiners are critical of candidates who present carpentry and no long term care.

The records, study casts and radiographs will be evidence that the candidate can:

a. Take a good history and carry out a full clinical assessment.

b. Plan treatment, fully, considering all options and demonstrating care in meeting the patients’ needs.

c. Account for your treatment and any changes to the Treatment Plan.

Philosophy: Compare Case Presentations with this maxim:

The treatment carried out does the minimum harm, with minimum cost and intervention, provides maximum benefit and gives maximum restoration of function.

What Is Expected: Candidates will be expected to show ability to:

a. Take a good history.

b. Treatment plan, discuss treatment prognosis and future management of the patient’s care.

c. Substantiate completion of treatment with supporting evidence such as radiographs, photographs and models.
Stay Mainstream: Complicated cases get in depth questioning. Candidates are examined from the level they present. Questions on advanced or exotic treatment regimes may be taken from a review of current thinking by examiners - so candidates should seek specialist advice for items that are not mainstream.

Getting Help: Peer Review of draft submissions is vital, so candidates should get the help of colleagues. This should take place well before cases are completed and sent to the College.

What The Examiners Look For: Ask yourself these questions about candidates’ presentations.

a. If needed, was there evidence of informed consent?

b. Could standard case history headings be detected from the notes?

c. If the patient presented a problem, was its history described?

d. Was a medical history taken/updated and were adequate social factors (eg. smoking) explored?

e. Was the clinical examination sufficiently comprehensive, particularly with reference to soft tissues and periodontal tissues?

f. Were all relevant special tests undertaken and were radiographs reported upon.

g. Was preventive advice given?

h. If necessary, was progression of disease monitored?

i. Were treatment options (if any) listed and the treatment plans set out clearly? Were escape routes identified where treatment outcomes were dubious?

j. Were treatment outcomes satisfactory?

k. Was there evidence of continuing care plan (recall interval, highlighting of specific monitoring needed etc)?

l. Was there evidence that a second opinion was sought if needed?

What to Look For With Case Presentations:

a. **Complex Cases.** Use skills appropriate to clinical experience.

b. **History.**

   (1) Records and supporting evidence (eg. Radiographs) not available.

   (2) History scanty or not recorded.

c. **Planning.**

   (1) Must account for treatment and changes to treatment plans.

   (2) Support treatment choices.

   (3) Discuss treatment prognosis and future management of patient’s care.
d. **Treatment.**

   (1) Substantiate completion (radiographs, photographs and models)

   (2) Must meet patient’s needs.

e. **Not to Be Left Out.**

   (1) Relevant social, medical and dental history.

   (2) Include copies of radiographs.

   (3) Findings from special investigations.

   (4) Photographic illustration of pertinent assessment and treatment stages.

   (5) Include copy of consent.

   (6) Keep a copy for yourself and keep original radiographs, models and photographs.

**Predictors of Unsatisfactory Viva Voce Outcome:**

a. **Pathology Not Diagnosed.**

   (1) Caries, bone loss, calculus, periapical opacities or radiolucency, impacted teeth.

   (2) Understanding of differences between smooth surface and fissure caries (and indications for use of sealants and fluoride materials).

   (3) Poor diagnostic quality of investigations, especially radiography. Film holders and collimated beams to be used.

   (4) Ineffective monitoring.

   (5) BPE or equivalent must be used, followed by appropriate investigation. Scores must match pocket charts and evidence on radiographs. Specific scores require specific treatment regimes.

   (6) Why, when and how to mount study casts on articulators and how to use the information on these.

   (7) Why, when and how to use results of diet analysis.

b. **Inadequate Records.**

   (1) Investigations and advice must be recorded on dental record cards.

   (2) Appropriate indices not used or recorded.

   (3) Long term care and monitoring not planned.

   (4) Medical, social and dental history taking inadequate (and/or not acted upon).
c. Treatment.

(1) Treatment rather than oral health care presented.
(2) Scientific basis for treatment, material and techniques not understood sufficiently.
(3) Caries etiology and prevention inadequate.
(4) Poor practice with implications for patient safety.
(6) Fixed prostheses: lack of embrasure, poor pontic design, over-contouring etc. not seated; occlusion not satisfactory (or recorded).
(7) Philosophy of periodontal treatment not clear: type of debridement; recording disease activity; incorporation with restorative planning.
(8) Removable prostheses: flanges, retentive factors; occlusion, design.
(9) Impressions: techniques; contamination/cross infection management.

d. Poor Choice of Case.

(1) Bad attenders and poor motivation.
(2) Bad habits (eg. parafunctional).
(3) Behavioural and genetic factors (eg. Down’s syndrome).
(4) Far too much treatment needed: difficulty in reaching an outcome.

Behaviour at Viva Voce:

Examiners in Oral Examinations Expect Candidates to

1. Be polite.
2. Be punctual.
3. Not argue with them.
4. Not criticise them.
5. State points clearly without waffling or mumbling.
6. Admit weaknesses, such as points they are unclear about and to state how they would obtain information to deal with these.
7. Not to bluff.
8. Talk about any topic which the examiner introduces.
NOTES ON LOG DIARY PREPARATION

The Case Reports:

- Anonymised and typed in the third person.
- Be typed on one-sided sheets of A4 paper.
- Each case separately mounted in a display book with clear pockets.
- 5000 word allowance is a maximum.
- Photographs.
- Radiographs.
- Copies of relevant documents, patient’s consent, candidate’s declaration.
- Keep a copy with originals and take this to the examination.

The Case Selection:

- Four cases illustrating a wide range of diagnostic and treatment problems that have been carried out in a primary care setting.
- Treatment appropriate to candidate’s skills - complexity not an advantage.

A Possible Template and Check List:

1. Making a Diagnosis.

   a. Age, sex and occupation.

   b. Medical History:

      (1) Cardiovascular – Rh Fever, Heart, BP, congenital, anemia, blood, healing, swollen ankles, chest pains, shortness of breath.

      (2) Respiratory - sinusitis, coughs/colds, TB ...

      (3) Genito-urinary - pregnancy, STD, kidney ...

      (4) Gastro-intestinal - jaundice, diabetes, ulcers, indigestion ...

      (5) Skelto-muscular - joints, cramps, arthritis.

      (6) Dermatological - rashes, irritations, tattoos

      (7) Neural system - epilepsy, faints, migraine, pain, numbness.

      (8) Allergies - hayfever, asthma, rashes, drugs.

      (9) Medications - what, why, when, how, side effects.
c. Social History.
   (a) Family - married? Children /grandchildren /ages.
   (b) Smoking.
   (c) Alcohol.
   (d) Other habits - betel quid, thumb sucking ...
   (e) Contact sports.
   (f) Personal circumstances - lifestyle, work etc.

d. Dental History
   (a) Previous treatment - where, when, how often, who.
   (b) Successes/failures.
   (c) History of accidents, tooth loss, dentures, bridges etc.
   (d) Pain - where, when, amount, relieving/exacerbating factors, analgesic - type, dose, frequency, effect.
   (e) Gums - bleeding, soreness, food traps, bad breath.
   (f) Teeth - chewing, grinding, clenching, soreness, breaks, sensitivity, headaches, muscle pain, clicking/noises, movement.
   (g) Aesthetics - patient's assessment.
   (h) Oral hygiene habits - type and frequency of brush, floss, other aids..
   (i) Dental habits - pipe smoking, breaking thread with teeth etc.
   (j) Diet - quality, frequency, quantity.
   (k) Understanding, motivation, commitment.

e. Extra-oral Examination.
   (1) General - height, weight, demeanour.
   (2) Face - colour, tone, symmetry, scars, features, expressions
   (3) Aesthetics - smile profile, vertical dimension.
   (4) Head and neck - swellings, lymphadenopathy.
   (5) TMJ - click, crepitus, tenderness, pain.
   (6) Mandibular movement - displacement, deviation, limitation.
f. Intra-oral Examination.

(a) Soft tissue screening.

(1) Lips, vestibule, buccal mucosa, tongue, floor of mouth, palate, pharynx.

(2) Tests - haematology, biopsy, bacteriology/virology, urine analysis etc.

(a) Record of hard tissue history.

(1) Tooth charting - presence/absence, white spots, exposed dentine, impactions, roots.

(2) Restorations - type, margins, extensions, wear, discoloration, age.

(b) Caries and vitality screening.

(1) Transillumination, caries detector, radiography vitality tests.

(2) Percussion, EPT, hot/cold, test cavity risk markers.

(c) Oral health and hygiene screening.

(1) Dietary charts,

(2) Indices - plaque, oral hygiene.

(d) Periodontal screening - BPE.

(1) Indices - periodontal, gingival, mobility, furcation, ...

(2) Pocket charts, recession charting,

(3) Gingiva - colour, texture, tone, thinness, margins, papillae clefts, festoons, fenestrations.

(4) Radiographs - parallel radiographs.

(e) Occlusion screening.

(1) Shape of arch - narrow, normal, broad.

(2) Arch relationship - Angles, incisor, molar occlusal planes, anatomic planes, cross-bites.

(3) Wear - use an index, study casts, photographs.

(4) Functional relationships - intercuspal, centric relation, slides from ICP to CR, working side and non working side contacts, intrusive contacts, rest position, occluso-vertical dimension, secondary occlusal trauma, fremitus. Study casts, articulation. Shimstock and fine articulating paper, T-Scan etc.
(5) Cracks and fissures - detecting solutions.

(6) Aesthetic screening - smile, lip line, gums, soft tissues, proportions.

(7) Critical evaluation - sight, smell, touch, sound, feel

g. Special Baseline Records.
   
   (a) Charting - tooth, restorations, caries, diet etc.
   
   (b) Indices - plaque, gingival, bleeding etc.
   
   (c) Radiographs.
      
      (1) Orthopantomograph.
      
      (2) Long cone parallel radiographs.
      
      (3) Other.
   
   (d) Study casts.
   
   (e) Articulation - semi adjustable with face-bow.
   
   (f) Surveying.
   
   (g) Photographs.
   
   (h) Sensibility tests.
   
   (i) Special tests - risk markers, pathology.

h. Diagnosis Based On:
   
   (1) Patient Complaint.
   
   (2) Signs and symptoms.
   
   (3) Special tests.
   
   (4) Experience.

2. Plan of Treatment Based On.

   a. Patient needs vs wants.
   
   b. Patient susceptibility vs adaptability.
   
   c. Practitioner’s diagnosis/ses and prediction of prognosis/ses.
   
   d. Patient compliance to treatment and continuing care.
   
   e. Options of treatment and plans for the future.
   
   f. Plans for failure.
3. **Treatment Plan.** Written, with options, given to patient, ensure informed, understood, consent for treatment.

   a. **Emergency - Eliminate Acute Problems and Pain.**
      
      (1) Pain reduction.
      
      (2) Control of infection.
      
      (3) Restore aesthetics.
      
      (4) Restore function.
      
      (5) Referral/2nd opinion.

   b. **Primary Phase - Eliminate Active Disease, Achieve Stability.**
      
      (1) Establish treatment objectives.
      
      (2) Eliminate active disease.
      
      (3) Achieve oral stability.
      
      (4) Assess patient participation and co-operation.
      
      (5) Referral/2nd opinion.
      
      (6) Reassessment.

   c. **Secondary Phase - Specialised Treatment.**
      
      (1) Reconfirm treatment objectives.
      
      (2) Orthodontics.
      
      (3) Complex oral surgery.
      
      (4) Periodontal Surgery.
      
      (5) Endodontic Surgery.
      
      (6) Reassessment.

   d. **Reconstructive Phase - Definitive Treatment**
      
      (1) Recheck Diagnostic Criteria.
      
      (2) Reconfirm patient co-operation.
      
      (3) Reconstruct.
      
      (4) Reassessment.

4. **Maintenance and Monitoring.**

   a. Compare baseline records:
(1) Indices, charts, radiographs, casts, tests etc.

b. Preventive maintenance:

(1) Prophylaxis, fluoride, diet, habits etc.

5. **Appraisal of Treatment.**

   a. The aims of the treatment.
   b. Problems encountered and solved.
   c. Reasons for using the materials chosen.
   d. Reasons for chosen treatment and technical prescription.
   e. Were objectives achieved.
   f. Treatment outstanding.
   g. Patient’s feelings at conclusion.
   h. Practitioner feelings at conclusion.
   i. Lessons learnt.

6. **Administration and Record Keeping.**

   a. Contemporaneous notes.
   b. Charts, indices, other artefacts.
   c. Referral letters.
   d. Laboratory prescriptions.
   e. Communications with patient.
   f. Recall information.
THE IMPORTANCE OF VIVA TECHNIQUE

Viva examinations are the greatest cure for constipation known to man. In order to reduce the demands on Valium and your fingernails, the following tips are suggested for the Unseen case & General Oral examinations:

1. Stay positive.
2. Concentrate on what you should do, not the consequence.
3. If you do not understand the question, ask the examiner politely to elaborate more.
4. Make sure you understand the question before you give answer. Then answer exactly what the examiner asked.
5. Talk slowly and don't mumble. If you don't know the answer, admit it and say something that you know in relation to the subject. Don't keep silent. Avoid waffling.
6. Do not argue with the examiners - even if you think you are right. Some examiners like to challenge you, let them win.
7. Be aware of sample questions like- what is caries? You are in big trouble!
8. Smile - even if your teeth are firmly clenched.
9. REMEMBER - EXAMINERS WANT YOU TO PASS! Don't give them a reason to fail you or you fail by yourself.
UNSEEN CASE CLINICAL EXAMINATION - VIVA TIPS

This ODTP examination will be presented as study models, radiographs and photographs with a brief history.

A TYPICAL BRIEF HISTORY

Mr. A, who is a fit 25 year old executive, arrives at your surgery for the first time complaining of pain from a lower right first molar tooth. He requests that you treat the pain then “sort his teeth out”.

SUGGESTED TECHNIQUE FOR TREATMENT PLAN ELEMENT OF VIVA

1. LIST FURTHER INFORMATION WHICH YOU REQUIRE.
2. GATHER INFORMATION FROM MATERIEL PROVIDED.
3. LIST PROBABLE TREATMENT NEEDS.
4. MAKE PROVISIONAL TREATMENT PLANS.

1. LIST FURTHER INFORMATION WHICH YOU REQUIRE

The information provided is usually inadequate to make a valid series of treatment plans. Ask your examiners to clarify if any of the following points are relevant before you present your plans.

Medical and Social Histories
Dental History
Availability of Patient for Treatment
Ability of Patient to Pay for Treatment
Condition of Soft Tissues and Gingiva
Occlusion (if study models are not articulated)

Mention any further investigations which you would ideally like to carry out eg. further radiographs, vitality tests, etc, before you suggest treatment plans.
GATHER INFORMATION FROM MATERIAL PROVIDED

Systematically examine the models, radiograph and photographs.

In particular look for:

Carious or possibly carious lesions
Misplacement or impacted teeth
Unopposed teeth
Periodontal problems - Gingival inflammation
       Loss of attachment
Non vital teeth
Soft tissue abnormalities
Iatrogenic factors
Location of missing teeth
Occlusion
Other relevant information

LIST PROBABLE TREATMENT NEEDS

Your list will be based on the information gathered from the material provided, supplemented when you ask your examiners for further details and clarification at the beginning of your viva.

MAKE PROVISIONAL TREATMENT PLAN

Phase 1 Elimination of acute problems and pain.

Phase 2 Establish stability.

Phase 3 Definitive treatment plan.

Phase 4 Monitoring and Maintenance.

PHASE 2 ESTABLISH STABILITY

Periodontal
Caries
Occlusion
Correction of impacted, misplaced or unopposed teeth corrective surgery eg. crown lengthening, tuberosity reduction, etc.
PHASE 3  DEFINITIVE TREATMENTS

Argue options and the rationale for your treatment plans.  Examples of this include:

- Bridge or Removable Prosthesis
- Adhesive or Conventional Bridge
- Bridge Design
- Implants

WHEN YOU ARRIVE AT THE VIVA TABLE

1.  Ask for further information.

2.  Give a logical case presentation.

   Mr. A, a 25 year old executive..................
   PCO
   MH
   DH

   On Examination

   Extraorally
   Intraorally - Soft Tissue
   Occlusion
   Teeth
   Periodontium

3.  Then arrive at your treatment plan, having considered all possibilities from no treatment to full clearance.

THE GENERAL ORAL EXAMINATION

Listen carefully to what the examiners say.

You may be shown slides, radiographs, a skull or just asked questions.

Describe the features that you see on slides and radiographs in a logical sequence.

Don’t be afraid of asking your examiners questions to clarify points.

Try to answer questions in a structured manner.

If you give a differential diagnosis, give the commonly occurring diagnosis first.

If you are confident about certain topics, plant points in your answers for the examiners to seize on.