



HOW ARE YOUR Teeth?

A NEW EXHIBITION EXPLORES
DENTAL HEALTH THROUGH THE AGES



ALSO INSIDE

07 USING LOCUMS
MANAGE THE RISKS

10 MAKING THE MOVE
FROM NHS TO PRIVATE

AN MDDUS
PUBLICATION





Welcome to your SoundBite

WHEN I graduated from dental school many years ago, all the general practice vacancies were for NHS associates. These days many NHS dentists are choosing to work in the private sector, but this transition is not without risk. My article on [page 10](#) looks at issues around consent, fees and the pitfalls of "upselling".

Most dentists will have had that sinking feeling when a treatment has not gone to plan or a patient returns unhappy. It may be tempting to avoid "riskier" procedures, but this will likely only increase patient dissatisfaction and lead to deskilling. Early practitioner adviser Laura McCormack looks at the risks around defensive dentistry on [page 5](#).

Locum dentists provide a vital service - but is your practice fully prepared for temporary staff? Risk adviser Alan Frame offers top tips on [page 7](#). A successful working relationship between partners/principals and

practice associates relies on having a comprehensive contract in place, yet many do not. Dentist-turned-business coach Alun Rees explains on [page 6](#).

Oral cancer is rare but can be devastating when missed. Professor Stephen Porter considers the pitfalls in diagnosis on [page 8](#). Providing care to a child whose parents are estranged can be a real challenge for practices. Our article on [page 4](#) offers some advice.

From the gruesome Middle Ages to modern day Hollywood smiles, dentistry has come a long way over the past centuries. Check out some fascinating photos from a new Wellcome Collection exhibition on [page 12](#).

And the misdiagnosis of a prolonged socket infection is the focus of our case study on [page 14](#).

• **Doug Hamilton**
Editor



CALL FOR DENTISTS TO SEE EXTRA 70,000 CHILDREN

DENTISTS are being urged to see more pre-school children in a bid to tackle tooth decay.

NHS England is calling for an extra 70,000 under-fives to have check-ups as part of its *Starting Well Core* campaign which aims to raise awareness among 24,000 dentists across the country.

Experts recommend children are taken for an NHS dental check-up before their first birthday but currently only one in 10 children under two have seen a dentist. This is despite the fact that NHS dental treatment is free up to the age of 18, or 19 for those in full-time education.

The latest figures show that more than 140 children a day - some as young as one - are having decayed teeth removed at great cost to the NHS.

Chief dental officer for England Sara Hurley said: "Regular visits to your dentist from a very early age is key to developing habits that lead to a lifetime of good oral health. The NHS is providing additional support to dentists to help them see more children so that painful and distressing dental operations, later in life, can be reduced."

The *Starting Well Core* initiative will offer additional support to dentists including training materials and guidance.



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COVER PHOTOGRAPH: WELLCOME COLLECTION. ABRAM GAMES POSTER DETAIL. COURTESY NAOMI GAMES

DATA OPT-OUT FOR PATIENTS IN ENGLAND

THE "national data opt-out" has been launched in England allowing patients to refuse to have their confidential information used for research or planning purposes.

The move is in line with recommendations from National Data Guardian Dame Fiona Caldicott's *Review of data security, consent and opt-outs*.

Under the new rules, patients can opt out online using their NHS number, or by other means including a printable form and telephone service. Previously, opt-out requests were managed by GPs. Those who do not wish to opt out do not need to take any action.

The new system will have a phased introduction before going fully operational in October 2018. More information is available at www.nhs.uk/your-nhs-data-matters.

NEW MANDATORY DATA SECURITY TOOLKIT

A NEW Data Security and Protection Toolkit has been launched by NHS Digital which all organisations in England with access to NHS patient data and systems must complete to help keep patient information safe.

The new toolkit replaces the previous Information Governance Toolkit and is an online self-assessment tool that enables health and social care organisations to measure and publish their performance against the National Data Guardian's 10 data security standards and key elements of the General Data Protection Regulation (GDPR).

Organisations which provide health services or connect to national systems will be required to complete the toolkit annually to provide assurances that they are practising good data security and that personal information is handled correctly.

Access it on the NHS Digital website: tinyurl.com/ybkugyix

LAUNCH OF NEW DUTY OF CANDOUR PROVISIONS IN SCOTLAND

NEW duty of candour provisions in Scotland came into effect on 1 April.

The provisions, as defined in the Health (Tobacco, Nicotine etc. and Care) (Scotland) Bill, set out a range of things that must happen when there has been an unexpected event or incident resulting in death or harm during health or social care.

Principles of candour exist in many organisations and within professional codes of conduct but the act introduces a statutory organisational duty of candour on health and social care services in Scotland.

The Scottish Government has produced a guide on the new provisions as well as three factsheets at: tinyurl.com/ya7tm8xn

NO DPO EXEMPTION FOR DENTAL PRACTICES

THERE will be no exemption for dental practices in the requirement for all UK primary care providers to have a dedicated data protection officer (DPO).

Government ministers rejected suggested amendments tabled by the Liberal Democrats following representations and lobbying by the BDA and other professional organisations when the Data Protection Bill was debated in Parliament on 9 May.

The new General Data Protection

Regulation (GDPR) did not require dental practices to have a DPO, but the UK Government put this duty on NHS primary care providers by including them in its definition of "public authorities".

The suggested amendments would have exempted dentists and other high street primary care providers from what the BDA calls a "huge and needless burden".

DPOs should have been in place since 24 May 2018.

DENTAL PHOBIA LINKED TO SOCIO-ECONOMIC FACTORS

HIGH dental anxiety is significantly associated with a lower health-related quality of life (HRQL) among adults, according to a study in the *International Dental Journal*.

A random selection of adults were interviewed and completed a questionnaire concerning dental anxiety and several socioeconomic variables.

Adults with dental phobia were almost twice as likely to be on a lower income. The study also found that dental anxiety can heavily impact patients both psychologically and socially, leading to feelings such as shame, poor self-confidence and social isolation. The results showed that patients who fear the dentist were twice as likely to suffer from poor oral health.

The Oral Health Foundation (OHF) says more than 10 million UK adults have some level of dental anxiety, with an estimated six million suffering from dental phobia.

OHF CEO Dr Nigel Carter said anxiety was a key reason why people avoided the dentist, adding: "With modern techniques, all dental treatment is now virtually painless. There really is no need to fear a visit to the dentist."



INEQUALITY GAP IN CHILD TOOTH DECAY

NEW data in England has revealed an almost 10-fold difference between some local authorities in the prevalence of child tooth decay.

The latest *Child Oral Health Survey* from Public Health England did find improvements in overall tooth decay levels but also wide regional inequalities, with 5.1 per cent of young children in Waverley in Surrey presenting with decay compared to 49.4 per cent in Pendle in Lancashire. Five-year-olds in Pendle have on average 2.3 decayed, missing or filled teeth compared to just 0.1 for those in Waverley.

Dental advocates including the BDA have expressed concern that authorities in England have failed to follow the lead set by devolved governments to bring supervised brushing to schools and nurseries.

They cite the Childsmile (Scotland) and Designed to Smile (Wales) programmes which use targeted interventions and have had success in reducing NHS treatment costs.

The BDA points out that tooth decay is the number one reason for child hospital admissions in England. Each day 170 children and teenagers in England undergo tooth extractions under general anaesthesia in hospitals in England at a cost of £36 million per year. The number of operations has increased by 17 per cent since 2012.

The BDA advocates a coherent and appropriately funded strategy to bridge the inequalities gap and urges greater effort from both local and national government.



"A child's biological mother will usually have parental responsibility"

Ireland, 1 December 2003 in England and Wales and since 4 May 2006 in Scotland.

Unmarried fathers can acquire parental responsibility by way of a parental responsibility agreement with the child's mother, or by getting an order from the courts. Married step-parents and registered civil partners can also acquire parental responsibility in the same ways. Parents who divorce do not lose responsibility.

Assuming here that both individuals have parental responsibility and equal rights as regards their daughter, the key consideration must always be what is in the child's best interests. Sometimes such best interests are not clear cut and certainly due regard should be paid to the views of those close to the child. Any fears expressed by the patient or parents should be addressed as far as possible. In this particular case it would be helpful to find out what particular reservations the mother has about the use of fluoride varnish. Further information could be provided on the well-established benefits in preventing tooth decay in children - and indeed how the treatment is being offered as part of major UK public health initiatives, including Childsmile in Scotland.

In most cases, consent from one parent is usually sufficient to carry out a treatment if deemed in the child's best interests (some require the agreement of both parents, such as vaccinations and male circumcision) but where there is serious disagreement, consideration should be given to withholding treatment if not essential. It would be reasonable to explain to the parents the difficulty this presents the practice and ask that they resolve their differences informally or possibly via family mediation. Should this fail, either parent can apply to the courts for a legal ruling (e.g. a 'specific issue order' or 'prohibited steps order').

In regard to attendance there is no obligation to inform the mother each time the child is taken by her father to the surgery. Again the parents should be encouraged to communicate with each other in the best interests of their child - though the mother is free to request access to her daughter's dental records according to standard practice procedures.

The practice should keep careful notes of discussions with all parties in such disputes, along with the justification for any decisions made. MDDUS also advises healthcare professionals to get in touch if in any doubt about the legalities of parental responsibility.

PARENTAL DISPUTE

What happens when estranged parents differ on dental treatment for their young daughter?

THE father of a 10-year-old girl recently made an appointment at our dental surgery to have fluoride varnish applied to her teeth. A day later we received a phone call from her mother - the parents are estranged - asking us to cancel the appointment, as she had "investigated" the use of fluoride varnish on the internet and was unhappy with the "safety risks". Our dental hygienist explained on the phone that fluoride varnish is a preventative measure and (given no contraindications) safe and effective. But the mother is adamant that she does not consent to the treatment. She is also demanding that we inform her the next time the father contacts or attends with the child at the surgery. What should we do?

Conflicts involving parents who disagree about the management of their child's healthcare are not uncommon and can be awkward with practices getting "stuck in the middle" of often bitter disputes. Emotions can run high and usually concern more than just the welfare of the child. In the situation described here the child is probably too young to make treatment decisions on her own behalf and you should first confirm who has parental responsibility and therefore legal rights in relation to the child.

A child's biological mother will usually have parental responsibility, as will the father if married to the mother at the time of the child's birth. Unmarried fathers will only have automatic parental responsibility if named on the child's birth certificate and the birth was registered after 15 April 2002 in Northern

ON THE DEFENSIVE

Dentist Laura McCormick discusses how practising defensively can lead to deskilling and unhappy patients

WE have probably all had that sinking feeling at some point in our careers when we realise something has not gone to plan or a patient returns unhappy with a treatment outcome. These experiences can be tricky to deal with and may negatively impact our self-confidence, making us doubt our skills as a dentist. For some, this may even affect our clinical decision making and ultimately the care we deliver to our patients.

Let's consider that one particularly challenging patient for whom if something can go wrong you can be sure it will happen to them. Your appointment book shows they are due in with you for the extraction of an upper 7. You recall explaining to them that root treatment was not possible on this tooth and extraction seemed the most appropriate option. Before they come in you check the medical history: all fine. You look at a previous radiograph: roots not close to maxillary sinus, no abnormal root morphology, so all looks good.

You are about to bring the patient in when you feel a nagging doubt creep in. You start to worry about the adjacent teeth. That upper 8 looked really spindly - what if I take that out inadvertently? Should you have given more thought to root treatment? You convince yourself it is too difficult, too risky and the patient can be demanding so out comes the referral form. You explain how complicated the procedure is and that it really should be done by a specialist. The patient is unhappy at having to take more time off work and is impatient for the procedure to be carried out. You reinforce the complexity of the procedure and feel relieved as they leave your surgery.

But was that referral really necessary? You have carried out numerous extractions before; why is this one different?

The term defensive dentistry is one we are hearing more frequently and describes a type of clinical practice where clinicians avoid what they perceive to be "high risk" or "difficult" procedures. These are usually procedures that could reasonably be provided but, due to the fear of a complaint, are not offered. While this might seem like a smart way to stay out of trouble and avoid complaints or General Dental Council referrals, the opposite is true. Dentists who practise defensively are effectively placing protection of their own position ahead of the patient's best interests. In doing so, they are actually more likely to be subject to a complaint from a dissatisfied patient like the one in our scenario above.

The GDC's *Standards* guidance states: "You should only deliver treatment and care if you are confident that you have had the necessary



"We cannot offer treatment options based on us being afraid"

training and you are competent to do so. If you are not confident to provide treatment, you must refer the patient to an appropriately trained colleague". This is sound advice but it is being used by some "defensive" dentists to justify referring any and all complex or unpredictable cases so as to minimise the risk of a poor outcome.

We cannot offer treatment options based on us being afraid. If you are appropriately trained, have risk-assessed the procedure and obtained consent from the patient, then you should proceed. If you lack confidence in your own ability then attend courses to increase your experience. It is vital that as clinicians we do not allow ourselves to become deskilled. To restrict your practice to a narrow range of "easy", "low-risk" procedures is the beginning of a downward spiral which can result in a loss of motivation and a lack of pride in your work which will adversely affect the quality and range of your patient care.

The most ironic part of this treatment avoidance approach is that it brings additional risks. How can we obtain valid patient consent if we did not initially offer all available treatment options? As dental professionals we

are obliged to listen to patients' concerns and wishes and fully explain all appropriate treatment options and their relevant risks, being sure to make contemporaneous and accurate notes.

How can we expect patients to trust us if they find out too late through Dr Google there were other treatment options they could have chosen? Trust between dentist and patient can only occur if the patient feels that you are acting in their best interests by arming them with all the facts to make an informed decision about their care. A lack of trust can lead to dissatisfied patients which can lead to complaints.

No dentist wants to feel like they are looking over their shoulder, scared of a patient complaint or GDC letter. But these things happen and MDDUS is here to advise and support our members through any adverse events that may occur due to your dental practice. It is likely that if all protocols have been correctly followed then MDDUS will be able to resolve the matter swiftly for you.

Laura McCormick is a dentist and early practitioner adviser at MDDUS



Dentist turned business coach
Alun Rees outlines the benefits to
 practice associates of having a clear contract

WORK IN HARMONY

THE noted personal coach Thomas Leonard wrote that all problems exist in the absence of a good conversation. For continued harmony you need an agreement of the relationship – in other words a contract.

Many of the situations that I have to deal with in my role as a business troubleshooter have arisen through a lack of communication and subsequent misunderstanding between two parties. I used to be surprised, but am no longer, to find that even in practices whose business systems are well organised and superficially tick all the legal boxes, no clear contracts exist between professionals.

I'm not referring to the arrangements between employer and employees where there is a clear legal obligation to provide a contract within the first few weeks with a job description and terms and conditions of employment. Rather I'm talking about the relationship between partners/principals and associates where, all too often, there is a "handshake" deal based on a presumed understanding between professionals. Problems often arise down the line when what was "understood" by one party differs from the other.

Dentistry isn't unique; I watched a friend's legal firm implode because the seven partners had no formal agreement. The lesson here is: if you're going to get into a business arrangement with someone make sure you know what is expected of you and how you can get away when (it's never if, always when) you want to. Similarly, you need to clearly understand the consequences for the business if the partnership ends due to someone else's departure.

Ensuring clarity

As an associate you may wonder why a contract is necessary. Surely both parties are honourable professional people and to impose paperwork on the relationship shows a lack of

trust? If that argument is put forward to you I suggest you start looking for another job. A contract ensures that there is clarity in your dealings, that both sides know what they have agreed to do for the other and what they can expect from each other.

The absence of a contract leads to confusion, uncertainty and misunderstanding which may lead to resentment, a failure of trust and an association that doesn't function at its best and ultimately may fail.

So what should be in your contract as a new associate? Many lawyers use the current BDA standard contract because it is considered the "industry norm". Ensure that the version you are offered is up-to-date which grants you a licence to practise dentistry.

Money, time and people

There must be clarity about what you will be paid as an associate: is it a fixed fee or a set or variable percentage (sliding scale)? If you are offered a set amount then you could have problems proving your self-employed status. What deductions will be made and how much are they? When can you expect to be paid? Any monetary targets should be clearly defined and stated in your contract. What is the provision for retention of fees if you relocate? Be clear about responsibilities for bad debts and, if you are working in the NHS in England or Wales, for clawback.

A contract should also state your expected working hours/days, how much holiday and study leave is considered acceptable and what happens should you be unable to work? Do you have the freedom to work at another practice? Will you have the services of a trained dental nurse? If you refer patients to the therapist or hygienist what are the financial arrangements?

Employment status

There is increasing talk that the HMRC may soon begin examining the self-employed

status of dental associates. You must ensure that you can be classified as self-employed and can prove it if challenged. For this you will need to engage with an accountant experienced in dealing with dental associates who can provide written confirmation of your status. Only an accountant can back you on this.

Professional situation

Exactly what does "full clinical freedom" mean? Where does that leave you if you want to develop new skills or concentrate on existing ones? What are the skill make-up and interests of the other practitioners?

Review

Change is the very nature of things. There should be a review of your associate's contract at your annual appraisal. Be prepared to argue your case for any improvement in your remuneration by showing your productivity and profitability. You must keep good records of income and new patients who specified that they want to see you, also of numbers of patients returning post-treatment and failures to attend/complete treatment.

If you feel that things are not going the way that you had been led to expect, try to achieve clarity and discuss anything with which you are not comfortable. Finally if you want to move on, ensure that any barring-out clause is "reasonable".

For a successful associate/principal relationship, make sure you get off on the right foot with a clear contract that meets both parties' needs.

Alun K Rees BDS is The Dental Business Coach. An experienced dental practice owner who now works as a coach, consultant, troubleshooter, analyst, speaker, writer and broadcaster - www.dentalbusinesscoach.co.uk

Preparation is key when employing temporary staff

MANAGING LOCUM RISKS



DENTISTS who run their own practices will likely need locum staff to fill occasional service gaps, be it a dentist, dental nurse, dental hygienist or therapist. Taking the time to get things right can not only reduce your own stress levels but also your personal and practice liability if things go wrong.

Preparation is key to managing the risks.

Key checks

First, it is vital to ensure that the locum you contract with is who they say they are. Check the evidence of their identity, inclusion on the relevant professional register and NHS performers list (if they are a dentist), as well as written evidence of their own personal indemnity arrangements. They should also provide appropriate current evidence of vaccinations. A dental professional's registration status can be checked, including any restrictions on their practice, on the GDC website.

You may also wish to obtain any relevant references and ask to see a copy of their enhanced disclosure report. Remember that dentists will already have had to provide this when applying to join the performers list.

It is advisable to check all of these details yourself even if you are using an agency as you may still be liable for any of the agency's negligent acts/omissions.

Advance warning

Ideally your locum will be provided in advance with written information outlining their expected duties to avoid any confusion or problems on their first day. You may also wish to consider informing patients booking appointments that they will be seen by a locum. Patients should certainly be advised of the change of practitioner by the reception team when they arrive for their consultation.

Induction

You have a responsibility to ensure that

the locum clinician is safely inducted into the practice. In advance of their arrival, it is important to have considered all the information and processes that are essential for them to safely undertake clinical care. This should include an orientation walk-around and introduction to the dental team. It is also a good idea to allocate a named clinician from whom the locum can seek assistance or advice. Ideally a record should be made of the completed induction. It is a mark of good leadership and indicates to inspectors that you take patient safety and staff training seriously.

Unique login

Locums should be provided with secure access to your clinical records system. A unique login and a time-limited password should be set allowing access to all electronic patient records. This ensures an audit trail of their actions is available should the future need arise. The use of generic login credentials and passwords are not advised and are unlikely to comply with data protection principles set out in the GDPR.

Protocols

Locums will need key contact information on systems, such as people and services available within the practice, as well as any onward referral protocols that are in place. Remember to provide instructions for use of any emergency equipment, and your sterilisation procedures should also be readily available.

You should highlight the practice procedure for registering complaints, near misses and other serious untoward incidents. This means that any issues experienced by the clinician can be reviewed and reflected upon and appropriate action can be taken by the practice. It is advisable to undertake a sample audit of the locum's work to identify any potential issues or problems. Be sure to obtain and regularly update their contact details in the event of future complaints or claims. Whilst the practice will be obliged to deal with complaints,

the individual locum must address any claims in which they are named.

Referrals

Practices will have a system in place for making urgent referrals concerning suspected cancer. Where the referral is made by a locum who then moves on, the practice must have a system to check the referral has been properly made, received and actioned.

The arrangements for urgent referrals to oral and maxillofacial or oral medicine clinics vary around the country. Some areas have an online referral system, others have a centralised fax number with a standard pro-forma. In other areas, the local units will respond to a telephone referral or a letter.

One risk for a locum is that they arrive in a new practice where they are unfamiliar with the idiosyncrasies of the local health networks. Problems can arise when they see a patient who needs an urgent referral, either with a suspicious lesion that might be cancer or a life-threatening head and neck swelling. In the latter case, a locum would know to refer to the local A&E department, however urgent access to oral and maxillofacial services (OMFS) might be delayed if the locum does not know at which hospital the on-call OMFS team is based.

A useful way of managing this whole process is to develop a generic information pack for all locums which should be regularly reviewed and updated.

Associate locums

Finally, if you are a dental principal and have an associate who is responsible for providing their own locum, make sure that they know to undertake the same checks and induction process. Alternatively, seek a written agreement with the associate that the practice will provide the pre-induction checks and the induction programme.

Alan Frame is a risk adviser at MDDUS

Professor Stephen Porter offers advice on recognising the signs of this increasingly common disease

SPOTTING

ORAL

THERE have been alarming trends around oral cancer in the UK in recent years. The number of cases has increased by almost a quarter, with the majority being oral squamous cell carcinoma (OSCC). Over the next 20 years cases are expected to rise by a third, with predicted mortality rates of 38 per cent.

Historically, most people in the UK have developed OSCC as a result of smoking or alcohol. In the last 20 to 30 years there has been a steady increase in the numbers of individuals who have developed OSCC due to infection by oncogenic (cancer causing) types of human papillomavirus (HPV). The carcinoma due to HPV is most likely to be in the posterior tongue and/or upper pharynx. Patients with HPV-driven oropharyngeal cancer do not have the traditional risk factors and tend to be male, aged under 50 and have a much better outcome than those who have similar cancer driven by tobacco and/or alcohol.

This article considers the key aspects of the initial recognition of possible OSCC and disease that may predispose to, or precede, such cancer.

Clinical features of likely oral cancer

OSCC can give rise to a range of different features but perhaps the most typical is a solitary ulcer without an obvious local cause. Tumours tend to arise on the lateral border of the tongue or the floor of the mouth (**Figures 1 and 2** above right) but can be anywhere within the mouth. The ulceration is often deep, has a rolled margin and the surrounding mucosa may be white to red in colour. There can be necrosis of the tissues and the ulcer can be fixed to underlying structures. Oral cancer can give rise to swellings that are usually firm and the overlying mucosa can be abnormal – for example, speckled. Enlargement of lymph nodes in the neck is not always evident and the absence of this, despite the presence of a solitary ulcer/lump in the mouth, should not rule out a mouth cancer diagnosis.

Pain is the most likely symptom of oral cancer. Others include paraesthesia or anaesthesia of the lip or, less commonly, the tongue, loss of taste sensation, limited mobility of the tongue, or sudden onset of tooth mobility in one area of the mouth (e.g. if the tumour is on the gum.) Late features of cancer can include unexplained weight loss and anaemia.

The easiest aide memoire for diagnosis of all mouth cancers remains a solitary lesion that has no obvious local or likely infectious cause.

Clinical features of potentially malignant disease

Oral cancer is usually preceded by a variety of clinically apparent lesions which have cells displaying atypia, collectively termed oral epithelial dysplasia. As with oral cancer, most of these lesions are solitary. Such disease comprises the following:

Leukoplakia

These are solitary white patches that can arise on any surface of the mouth (but typically the buccal mucosa and floor of mouth) and are not likely to be caused by local trauma. Lesions can be sub-classified into homogeneous, when there is a uniform whiteness throughout the lesion (**Fig. 3**), and non-homogeneous, when there are elements of redness, background erythema (**Fig. 4**) and/or raised areas (verrucous leukoplakias). The majority of isolated white patches do not contain oral epithelial dysplasia but the more non-homogeneous the lesion the higher the risk of malignant transformation.

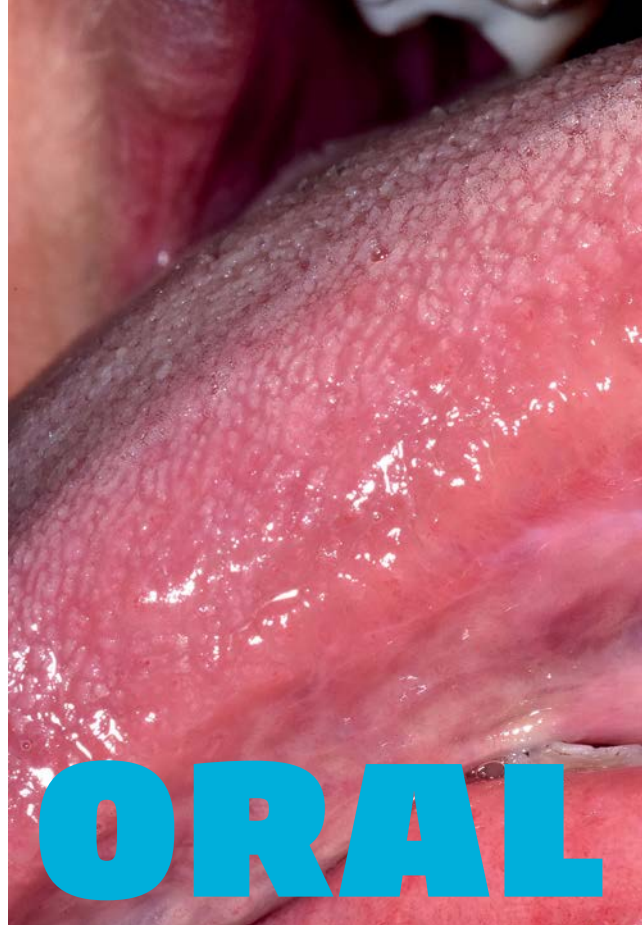
Erythroplakia

These isolated red patches of the oral mucosa or gingivae arise in the absence of a local cause (e.g. trauma or clinically evident candidal infection). Such lesions are rare but usually represent areas of severe oral epithelial dysplasia or carcinoma-in-situ. These can be an early manifestation of OSCC, so any patient with an isolated red patch that is not due to local trauma warrants immediate biopsy or referral to an appropriate centre.

Other potentially malignant disorders

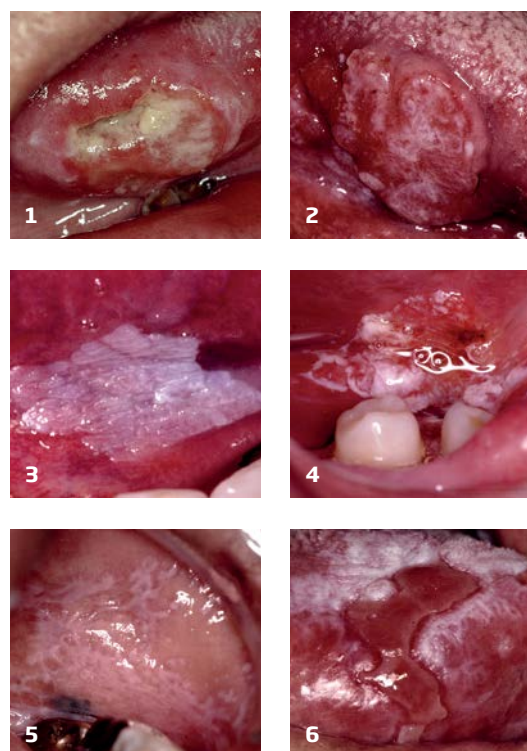
Oral epithelial dysplasia and carcinoma-in-situ (when all layers of the epithelium have cellular atypia) can arise in a number of pre-existing oral disorders. The most common is oral lichen planus (OLP). This typically manifests as bilateral white patches affecting the buccal mucosae, gingivae and/or dorsum of tongue. The white patches (**Fig. 5**) are usually painless however, areas of erosion (erosive OLP) and ulceration (ulcerative OLP; **Fig. 6**) can give rise to painful symptoms. About one per cent or more of patients with OLP will develop clinically apparent

“Assume all solitary persistent lesions without an obvious cause are suspicious”





MAIN PHOTOGRAPH: SCIENCE PHOTO LIBRARY



oral epithelial dysplasia (i.e. leukoplakia or erythroplakia) and later OSCC, regardless of the type of OLP or how it has been managed.

Similarly, about four per cent of patients with oral submucous fibrosis (OSMF; caused by exposure to a variety of agents, particularly arecoline in areca nut) will develop OSCC, while around a quarter will have leukoplakia. This disorder causes thinning, fibrosis and grey pigmentation of the oral mucosa, particularly of the buccal mucosa (**main picture**).

Other potentially malignant disorders of the mouth include scleroderma, chronic mucocutaneous candidiasis (and perhaps chronic hyperplastic candidiasis), rare instances of gross deficiency of iron, vitamin B12 and/or folic acid and some genetic disorders. Warts of the mouth are not caused by oncogenic types of HPV and thus are not considered potentially malignant.

The role of the GDP

A quick diagnosis is key and the box on the right provides some simple advice. If the clinical picture has significantly improved following removal of any likely local traumatic causes then generally this means the lesion was not cancer. However if there is no substantial improvement, or concerns remain, then specialist referral is warranted.

Patients should be informed of the possibility of a malignant lesion or disorder and the importance of attending the specialist appointment. It may also be appropriate to urge caution in googling symptoms as information found on the internet will often be inaccurate, alarming, biased and/or difficult to understand.

Contemporaneous notes should be recorded that provide an accurate indication of what the clinician observed, thought and actioned, as well as indicating that the patient was made aware of the possible diagnosis and was agreeable to the way forward. Simply writing "possible cancer, patient reassured" is inappropriate and opens the door to criticism.

Conclusion

Any solitary, odd and/or destructive lesion that has no obvious local cause and/or is present in a background of disease known to be potentially malignant should be considered as cancer until proven otherwise. Healthcare providers should inform patients of their thoughts, arrange timely and appropriate referral to a specialist, as well as maintain accurate and contemporaneous records.

Professor Stephen Porter is institute director and professor of oral medicine at UCL Eastman Dental Institute

Simple steps for diagnosis and management of oral cancer

- Assume all solitary persistent lesions without an obvious cause are suspicious.
- Remove all potential sources of local trauma and review (e.g. within two to three weeks). If the lesion has not reduced significantly within this time, regard it as suspicious and refer appropriately.
- Do not assume that a patient who does not smoke tobacco or drink alcohol cannot have oral cancer.
- Tell the patient of your clinical judgment and decision to seek specialist advice.
- Refer patients with lesions that are suspicious and have not responded to removal of likely local causes - but be sensible (multiple superficial ulcers are very unlikely to be cancer). Refer patients with non-healing extraction sockets.
- Ensure all relevant details are included in the referral and ensure it is marked urgent.
- When oral cancer is not in doubt, call the nearest appropriate specialist to gauge their thoughts and wishes.
- Referrals can be emailed provided principles of GDPR/Caldicott are followed.
- Keep accurate, contemporaneous and legible clinical notes (including a record of any correspondence with patients, relatives and specialists). If possible, keep clinical images of the lesions.
- Keep contact details of local specialists up-to-date.
- Know the wishes of local specialists regarding the early management of potential malignancy.
- Ensure staff are up-to-date with significant trends in the diagnosis of malignant/potentially malignant disease.

WHEN I graduated from dental school many eons ago, some of my colleagues began to explore the possibility of working outside the NHS. At that time private dentistry was, in Scotland at least, something of a mythical creature, like kelpies, Nessie or a successful football team.

A few years later, the now infamous NHS contract of (if memory serves) 1992 was implemented. Aggrieved by the fee cuts, some of my colleagues began to explore the possibility of working outside the NHS. To what extent this factored into the subsequent shortage of high street NHS dentists is hard to quantify. However, it gradually became apparent that, despite the introduction of a number of allowances designed to entice former NHS dentists back to the fold, some were enjoying life beyond the GP17 forms.

The attractions of the move are obvious. Suddenly an entire layer of bureaucracy evaporates. No need to seek prior approval, adhere to the statement of dental remuneration (SDR), submit claim forms or await, with a degree of trepidation, dental reference officer (DRO) requests. This new-found independence also allows greater clinical and financial freedom. The private dentist could set fees higher than those prescribed in the SDR which in turn permitted a less harried working day.

But those who leave the fur-lined rut which is NHS practice are soon faced with the insecurities of private sector work. Charges need to be fixed at a level which sustains the business but without driving patients into the arms of the nearest NHS practice. The comfort blanket of the NHS pension is also lost. In Scotland, entirely private practices now fall under the jurisdiction of Healthcare Improvement Scotland, making them subject to unannounced inspections.

Mixed practice

It is not surprising that many practitioners opt to work in NHS dentistry, but with an element of private activity. NHS 'brand loyalty' virtually guarantees a level of patient footfall and, in Scotland, monthly rolling-on fees. Yet this compromise brings its own hazards. The fact is that, irrespective of the potential benefits of private treatment, NHS patients are entitled to be rendered dentally fit on an NHS basis. This means there will be items of service or courses of treatment which will be unprofitable or professionally frustrating but which the dentist will be contractually obliged to offer to NHS patients.

Any attempt to circumvent this requirement can have serious consequences. All of the UK NHS dental contracts effectively prohibit dentists from misleading patients regarding the quality and availability of NHS treatment. Anti-fraud teams can analyse claims to identify 'outliers' who are

not adhering to this rule. These contractual obligations are also mirrored in the GDC's *Standards* guidance and it is not uncommon for regulatory investigations to focus on allegations by NHS patients of 'upselling' or worse.

Of course there may be a perfectly plausible explanation as to why private rather than NHS dental treatment has been recommended. For example, in Scotland, the SDR was modified many years ago in order to end the provision of an NHS bonded crown on a molar (irrespective of whether it has migrated further than a wildebeest in the dry season and now features prominently in the patient's smile). Therefore, Scottish dentists who charge an NHS patient a private fee for a porcelain molar crown (having also offered an NHS metal crown) are not in breach of the relevant provision in their terms of service. However, if this private restoration is placed over an NHS root filling within the one course of treatment, that would be a different story.

Those who work under the English regulations do not benefit from such clarity – very few types of treatment, such as sports mouthguards, are definitively unavailable on the NHS. The item of service system, with its restrictions and caveats, was shelved in 2006 in favour of UDA-based contracts. Whilst this arrangement allows private and NHS treatments to be carried out during the same course of treatment, patients' choices must still be properly informed and un-coerced. Nevertheless, an England-based practitioner may feel that, for example, the health of a patient's premolar can be secured by means of an amalgam. If the patient wishes a more aesthetically pleasing restoration, then it may be possible to levy a private fee without breaching any rules.

Payments

It remains critically important that the reasoning behind fees is explained to the patient in a comprehensible and transparent manner. In fact, the regulations in all jurisdictions stipulate that NHS patients must sign a cost estimate document – the FP17DC, HS45DC and the (now out-of-print) GP17DC (or equivalents) – acknowledging that the treatment plan includes a private element. The patients should be given a copy, with a duplicate retained in the practice records. If the plan changes, the patient should receive a revised form.

In addition to meeting contractual obligations, this approach also provides an audit trail in the event of a complaint or query about the basis upon which treatment was provided. Financial disputes may still arise, even where there has been an appropriate consenting discussion, where ballpark prices have been well publicised (as they must be) and where the paperwork is in good order. In fact, the incentive to demand a refund is usually proportionate to the fees levied.

Transitioning from NHS to private dentistry has its pitfalls.

Doug Hamilton offers some advice

LOOK BEFORE YOU





LEAP

Complaints

Complaints can follow a number of (potentially overlapping) paths. Patients who believe that the consenting discussion was framed in such a way as to lure them into accepting non-NHS options (aka 'upselling'), may report this to the GDC as a breach of professional standards. Patients who believe that the treatment (for which, lest we forget, they paid privately) was substandard may decide to litigate or to contact the Dental Complaints Service. The DCS exists primarily to arbitrate on unresolved disputes relating to private dentistry. However, should they find evidence of misconduct, such as unprofessional consenting discussions, they may refer the matter to the GDC.

Therefore, in mixed practice, NHS patients have a right to consider private treatments. However, it is crucial they are also offered all available and clinically justifiable NHS options in a neutral and professional manner. These discussions must be properly reflected in the records and all relevant paperwork must be completed.

This is a contentious and somewhat confusing area, so please contact MDDUS if you need more detailed advice.

Doug Hamilton is a dental adviser and editor of SoundBite

DENTISTRY THRO

A new exhibition looks back at the highs and lows of 300 years of dentistry

DENTISTRY in the 17th century was a dirty job that no self-respecting member of the established medical profession would deign to carry out. Pain relief was more or less unheard of and low-skilled barbers and blacksmiths would use the most basic of tools to pull rotten teeth.

It is these bad old days – long before the concept of oral hygiene had found its way into public consciousness – that the latest exhibition of the Wellcome Collection museum so vividly brings to life.

The new show, simply entitled *Teeth*, charts the evolution of our relationship with our teeth and of the dental profession itself. It winds its way from the grimness of medieval times, through the emergence of the smile in the 19th century (when dentistry finally began to have a positive impact), and on to the Hollywood smiles of modern day.

"The exhibition puts in context that the dentistry we experience today is a lot less invasive, quicker and more heavily managed in terms of pain," says curator Emily Scott-Dearing. "It certainly made me hugely grateful I live in the era that I do... But I'm definitely brushing my teeth more these days."

Drawing on the rich collections assembled by Henry Wellcome alongside loans from collections such as the British Dental Association museum in London, the exhibition features more than 150 objects. These include cartoons and caricatures, protective amulets, toothpaste advertisements and a range of chairs, drills and training tools.

Visitors can see the hygiene set used by Queen Victoria's dentist, the dentures belonging to King William IV and even Napoleon's silver-handled toothbrush. Also on display are the aluminium dentures made for an RAF corporal in a Burmese prisoner-of-war camp, plus a sinister looking wooden phantom head embedded with real human teeth.

Another theme explored in the London-based museum is dental phobia. The exhibition's final section, entitled *Our Friend the Dentist*, considers why anxiety remains so high despite the many technological advances. It is certainly easy to understand the fears of early dental patients judging by the rudimentary tools available at the time. A 17th century sculpture of a tooth extraction looks a particularly unpleasant experience.

- *Teeth* runs until 16 September, 2018 at the Wellcome Collection museum in Euston Road, London. Admission is free. Find out more at tinyurl.com/y7f5vp5b



Left: instrument set for Queen Victoria's dentist Sir Edwin Saunders (1814-1901). Right: Napoleon Bonaparte's silver-handled horsehair toothbrush.

DOUGH THE AGES



Clockwise from left: coloured engraving from 1811 of a French dentist showing a specimen of his artificial teeth and false plates; improvised denture for a British prisoner of war, 1940s; a phantom head adapted from a pharmacy sign c.1895; Mayan human tooth with jade inlay AD500-1,000.



DIAGNOSIS

PROLONGED
INFECTION**DAY ONE**

Mrs P is a 65-year-old former smoker with a history of periodontal disease and bone loss. She visits her dentist, Ms N, with a painful lower right second molar. Ms N diagnoses periodontal abscess. The tooth is removed and postoperative instruction given.

**DAY 15**

Mrs P returns to the surgery complaining of pain and a "sour taste" in the lower right quadrant. An infected socket is diagnosed and the socket is irrigated and drained appropriately. Ms N prescribes a course of antibiotics.

**WEEK 6**

Ms N notes the socket is still very inflamed and takes a radiograph. The socket appears clear and normal although there is obvious bone loss around the adjacent molar. Two weeks later Ms N notes that healing is better but still not complete. She schedules a review in one month.

**WEEK 10**

Mrs P is now complaining of pain in the adjacent lower right first molar. Ms N notes pus around the gum margin and that the adjacent socket is still inflamed. She extracts the first molar and again provides postoperative instruction.

**ONE MONTH LATER**

An incisional biopsy at the hospital confirms the lesion is squamous cell carcinoma. The patient undergoes extensive surgery followed by facial reconstruction and radiotherapy.

**WEEK 18**

Mrs P again sees Ms N who observes that the socket has still not healed and the inflamed tissue seems "red and cobbly". She makes a standard dental hospital referral.

**WEEK 13**

Ms N notes that the first molar socket is healing well but the second is still very inflamed. More antibiotics are prescribed and another review is scheduled in two weeks. At that appointment it is found that healing is still not complete and a further review is scheduled.

A LETTER of claim from solicitors acting on behalf of Mrs P is sent to the surgery alleging clinical negligence in the delayed diagnosis and referral for suspected oral cancer. It is claimed that had the condition been diagnosed and treated earlier the patient would have been spared radical surgery and the need for radiotherapy.

MDDUS commissions two expert reports. A GDP expert considers the care provided by Ms N and supports the decision to extract the second molar given the patient's history of periodontal disease and the radiographic evidence of bone loss. He also finds nothing inappropriate in the initial diagnosis and treatment of an infected socket and a suggestion that infection in the adjacent molar may have contributed to the slow healing.

The expert does however question why

after 13 weeks Ms N did not consider something more than just a slow-healing socket – especially when the adjacent molar had been extracted with normal healing. His view is that a referral should have been made at this point and certainly an urgent referral at week 18.

An expert report on causation (the consequences of any breach in duty of care) by an oral maxillofacial surgeon is also not supportive of Ms N's care. In his opinion the cancer would have been present before the first extraction and the failure to act on the abnormal healing contributed to the delay in diagnosis. This was further exacerbated by the lack of an urgent referral at 18 weeks.

The question of an earlier diagnosis leading to less radical treatment is not so clear cut. The expert states that the necessary surgery (involving tracheostomy, neck dissection, access

and free-flap reconstruction) would likely have been similar in scale if carried out earlier but the tumour would have been smaller and subsequent radiotherapy might not have been indicated. Prognosis in oral cancer is also better in general the earlier the diagnosis.

MDDUS negotiates a settlement in the case with the agreement of the member.

KEY POINTS

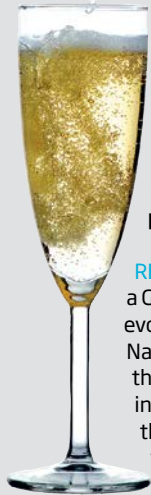
- Have a high index of suspicion in persistent mouth ulcers and slow-healing tooth sockets.
- Ensure urgent referral in any suspicion of oral cancer.
- Consider how chronic periodontal disease might mask other acute presentations.

OUT THERE

PROSECCO TEETH UK sales are soaring but it seems there is a dark side to sipping prosecco. Dentists are reporting an increase in the so-called "prosecco smile" as the triple whammy of acidic carbonated bubbles, alcohol and sugar (half a teaspoon in every flute) is rotting teeth. Fizz fans are being advised to consume less or use a straw and to avoid brushing for at least an hour after drinking.

CANINE CARE Dogs are being used by a dentist in Venezuela to help anxious children with autism, AP News reports. The specially trained pups - including Zucca the labrador and Perry the pug - lend a reassuring paw by donning fancy dress and sitting in the treatment chair with the young patients to calm their nerves.

REWRITING HISTORY Fossilised teeth found in a German river could prompt a rewrite of human evolution, it's been claimed. Researchers at Mainz Natural History Museum say it's inexplicable for the 9.7 million-year-old "ape teeth" to be found in the Rhine - six million years before and several thousand miles away from Africa where it's thought human ancestry began.



FROM THE MUSEUM

These balances were used in the late 19th/early 20th century for the preparation of amalgam (a mix of silver and mercury). In the larger scale, the long arm bracket celluloid cup measures the alloy while the shorter arm is for the mercury. The small balance, first sold in 1886, features one large and two small measuring cups.

PHOTOGRAPH: BDA MUSEUM

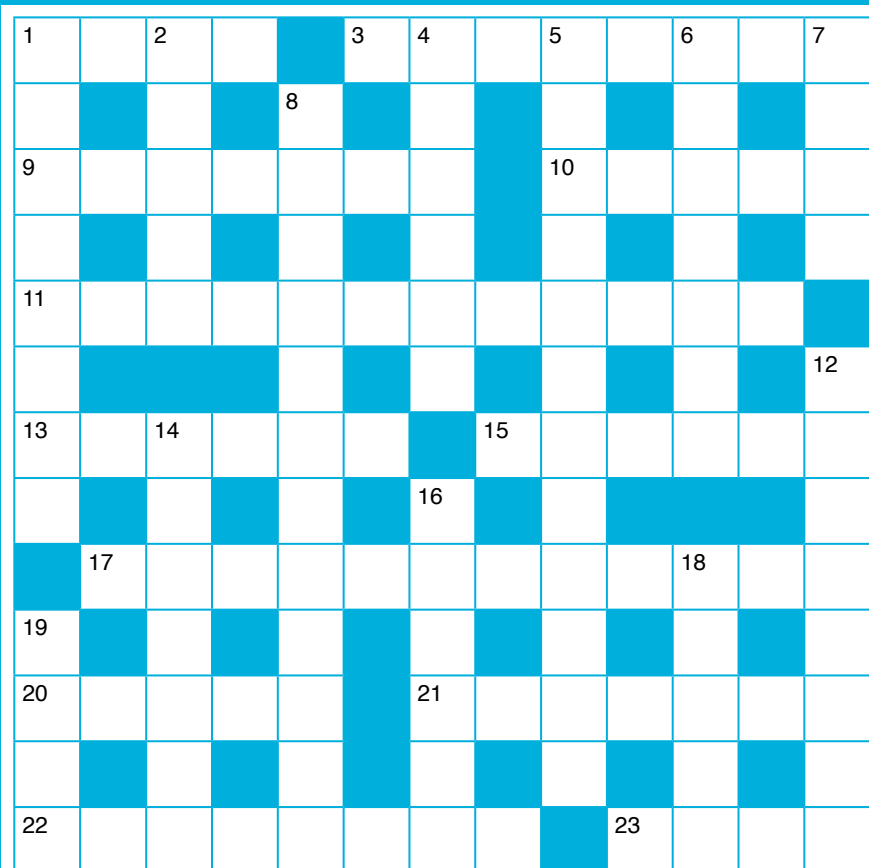
CROSSWORD

ACROSS

1. Fleshy growth on cockerel's head (4)
3. A premolar tooth; a tooth with two cusps (8)
9. The upper jaw (7)
10. Desolate (5)
11. Fixed in one's thinking (6-6)
13. Time sensitive (4)
15. Crown restoration placed over prepared natural crown (6)
17. Without vocals (12)
20. Evidence of innocence (5)
21. Disparage (colloq.) (4,3)
22. Boastful person (8)
23. Nile Rogers and company (4)

DOWN

1. Connective tissue covering tooth root (8)
2. Bitter lemon, say (5)
4. Archaic form of imams (6)
5. City redevelopment (5,7)
6. To go before (7)
7. Ditch (4)
8. No compromise available (3-2-7)
12. Profuse (8)
14. Soft tissues overlying the crowns of unerupted teeth (7)
16. Unarmoured cavalryman (6)
18. Used to cut or chew food (5)
19. Glad rags (4)



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