



STOP THE ROOT

DENTAL HEALTH IN UK CHILDREN

ALSO INSIDE

10 ANATOMY OF A
FITNESS TO PRACTISE CASE

12 JUNK TOOTH DENTIST
PAY WHAT YOU CAN AFFORD

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PUBLICATION





Welcome to your **SoundBite**

A NEW report found tooth decay among five-year-olds in England is at its lowest level in 10 years – yet the NHS spent a whopping £35 million on tooth extractions on under-18s in 2013-2014. So what is the real story behind child tooth decay? My article on [page 4](#) takes a closer look at this tricky issue and asks what can be done about it.

Despite improvements in NHS provision, many people still struggle to access affordable dental care. But an innovative new scheme is trying to change that. Dentist Nick O'Donovan tells us about his work volunteering with The Real Junk Tooth Project on [page 12](#).

As the General Dental Council investigate an increasing number of complaints against dentists, what should you do if one of their letters lands on your doorstep? Don't panic! MDDUS dental adviser Claire Renton has some

practical advice on what to expect on [page 10](#).

Clinical guidelines are a fact of life for dentists today, but following them may not always be the most appropriate way forward. Our article on [page 6](#) looks at the need for "logical" justification when deviating from accepted practice. Finding out what a patient wants and explaining all viable treatment options is key to informed consent. MDDUS dental adviser Doug Hamilton offers advice on [page 7](#).

The specialty of oral surgery is a dynamic and challenging one that doesn't require a medical degree. Find out more about the job on [page 8](#). Our case study on [page 14](#) looks at issues of consent surrounding an abscess incision.

• **Sameera Teli**
Editor

NEW ONLINE ORTHODONTICS RESOURCE

AN online resource to help patients make decisions about treatment has been launched by the British Orthodontic Society.

Orthodontics for Adults is designed for patients to read before they see a clinician.

It is divided into four parts, looking at the "why, how, where and who". Each section has key points or tips that guide the patient towards the information they need to make the right decision.

It covers areas such as brace types; teeth straightening; snoring and sleep apnoea; and orthognathic treatment, as well as FAQs about adult orthodontics.

The guide is accompanied by a video featuring Professor Tim Newton, professor of psychology as applied to dentistry, who advises on which questions to ask a clinician.

Access the resource at: www.bos.org.uk/adultorthodontics



UPDATED FACULTY GUIDELINES

THE Faculty of General Dental Practice (UK) has launched a new edition of its good practice guidelines on *Clinical Examination and Record Keeping*.

Gareth Kingstone, membership and marketing director at the FGDP(UK) said: "These guidelines are of relevance to all dental professionals, and we hope that this new edition will provide much needed clarity and practical assistance for the profession. We are very grateful for the contribution made by MDDUS to the development of these guidelines."

Order a copy on the FGDP(UK) website: tinyurl.com/gw246mh



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DENTAL HEALTH CRUCIAL IN DIABETIC PATIENTS

PRIORITISING the oral health of diabetics would not only save millions of pounds but also provide those patients with a better quality of life, says the Oral Health Foundation.

The charity cites research showing a statistically significant association between maintaining gum health and reduced healthcare costs among people newly diagnosed with diabetes.

Analysis of data from more than 15,000 adults aged 18-64 newly diagnosed with Type-2 diabetes found that those who had gum disease treated at an early stage had an average saving of almost £1,500 in healthcare costs over a two-year period.

Speaking about the findings, Dr Nigel Carter OBE, CEO of the Oral Health Foundation said: "Giving patients the information and treatment they need to look after their gums can help to preserve the oral health of millions in the UK while also saving NHS coffers."

President of the British Society of Dental Hygiene and Therapy, Michaela O'Neill, said that diabetic patients should be especially aware of the signs of gum disease.

She said: "Gum disease can potentially lead to tooth loss and people with diabetes are more at risk of aggravating gum disease. It then becomes a vicious circle, as gum disease can increase blood sugar which can lead to an increased risk of diabetic complications."

DENTIST ADDRESSES TO BE REMOVED FROM GDC REGISTER

THE full addresses of dental care professionals will no longer be published on the General Dental Council website under new plans announced by the regulator.

The registration number would be used as the main method of identification and to confirm professional status. The town/region in which they live may also be included.

Greater emphasis will now be placed on dental professionals displaying their registration numbers in practices so that patients can then easily search the register.

The BDA welcomed the "long-awaited change" which they described as a "step in the right direction". They had previously expressed concerns that the practice, which began in 2006, was "unnecessary" and "a potential risk to registrant safety."

A final decision on what information will be displayed online will be made by the GDC following a public consultation.

DECLINE IN TOOTH DECAY AMONG FIVE YEAR OLDS IN ENGLAND

TOOTH decay among five year olds in England has fallen to its lowest level in a decade, according to a survey by Public Health England.

It found that now less than 25 per cent of five-year-olds suffer tooth decay, which represents a 20 per cent reduction since the first oral health survey was conducted in 2008.

PHE believes the pattern of dental health improvement among the age group shows the impact parents and carers can have in establishing good dental care habits from an early age.

The *Oral health survey of 5-year-olds* examined the dental health of 111,500 children (16.5 per cent of the five-year-old population in England) and found that an estimated 166,467 five year olds suffer from tooth decay, compared with 177,423 in 2008 (31 per cent of the cohort).

Despite the national decline there is still significant regional variation in rates. In the North West, a third of five-year-olds suffer from tooth decay compared to a fifth in the South East. Higher deprivation levels tend to have higher levels of tooth decay.

Read more about this issue in our article on [page 4](#)



GDC APPOINTS NEW CHIEF EXECUTIVE

IAN Brack has been appointed as the new chief executive of the General Dental Council.

He formally took up the post in May having served as interim leader since January 11, 2016. He takes over from Elynn Gilvarry who stepped down in January after five years at the helm.

Mr Brack (pictured above) said: "I am committed to helping the GDC rebuild trust with patients, the professions we regulate and our partners. We will do this by achieving the ambitions set out in our three year road map, *Patients, Professions, Partners and Performance*."

DENTAL COMPLAINTS HANDLING MODULE

BRUSH up on your dental complaints handling knowledge by completing the MDDUS online module.

Members can login using their surname and membership number to access the CPD-verified module which takes around 45 minutes.

It looks at key issues including why patients complain, professional guidance on acting on patient complaints, and how to investigate and respond to them effectively.

Find the interactive module in the Risk Management e-learning centre at mddus.com: tinyurl.com/zg2bk9n

DENTAL CAREERS SITE MARKS FIRST ANNIVERSARY

A CAREERS website set up by a dental student is celebrating its first year online.

Bolton-born Shakil Umerji launched www.dentalcareersguide.com in 2015 as part of an elective project for his final year at Glasgow Dental School.

He enlisted the help of dental specialists and professionals to provide a range of articles and information resources to help trainees plan their careers.

He has received financial support from advertisers - including MDDUS - with all proceeds going to new Glasgow-based charity Dental Aid Network. So far Shakil has raised £1,000 for the cause which aims to provide dental care for those in need around the world. Their

next mission will be helping orphans in Kashmir in October 2016.

Shakil said: "What started out as a short-term elective project has grown into a really useful resource that is still going strong. We've got lots of articles and first-person pieces on different dental career options and I've had great feedback from people using the site.

"As an added bonus, 100 per cent of the revenue from advertising on the site goes to support Dental Aid Network - I cover the administration costs personally."

Shakil hopes to continue developing the site with plans for around 20 new articles over the coming year.

Existing articles look at endodontics, dental core training, prosthodontics and the management success of former football boss Sir Alex Ferguson.





As the cost of extracting decayed teeth in children soars, **Sameera Teli** takes a closer look at the causes and potential solutions for this long-standing problem

THE BATTLE AGAIN

IT WAS the end of World War 2 and the end of sugar rationing that saw consumption of one of the nation's favourite ingredients sky-rocket.

By 1958 it's estimated as much as 50kg of the stuff was being eaten per person per year in the UK. Great news for the sugar industry, but not so great for children's oral health. Back then, the *Children's Dental Health Survey* suggests as few as 13 per cent of five-year-olds had teeth without any caries, and only five per cent of 12-year-olds.

Fortunately improvements have been made. The introduction and widespread use of fluoride from the 1970s and greater access to dental care has greatly helped reduce decay levels through preventative measures. By 1983, half of British five-year-olds and nearly a fifth of 12-year-olds had teeth without any caries, rising in 2003 to 57 per cent and 62 per cent respectively.

Despite being almost entirely preventable, tooth decay continues to have a major impact on young people's lives - but why? And what can be done about it?

Social factors

It is useful to understand which groups are most at risk. Dental Public Health England's National Dental Epidemiology Programme recently reported on the prevalence and severity of tooth decay found in more than 110,000 five-year-old children through an oral health survey in 2015.

The number with decayed, missing (due to decay) or filled teeth was the lowest in almost a decade, with a 20 per cent decrease in the level of tooth decay since the last survey in 2008. A reduction in severity of decay was noted for the whole of the UK but not significantly so in all regions. Surveys in Scotland and Wales also showed comparable

outcomes over a similar time.

The UK report noted the impact of ethnic background, geographic location and deprivation on levels of tooth decay.

It found decay levels varied amongst ethnic groups, with children from Chinese and Eastern European backgrounds having higher levels of decay experience than any other ethnic groups. This information can be useful at a local level to help better tailor dental services for different patient types.

Geography also played an important part. The report highlighted significant variation across regions: higher decay levels were recorded in northern parts of the UK, particularly in areas with greater levels of deprivation.

So although overall levels of decay are falling, the inequality gap remains. Looking at data beyond local authority level in more detail could help show where the inequalities lie and where more focused help is needed.

In response to this survey, FGDP(UK) Dean Dr Mick Horton said: "The further increase in the proportion of young children free of tooth decay is great news, but the fact remains that a quarter of five-year-olds have an almost entirely preventable disease - and a quarter of these are not even receiving treatment."

Direct action

These patterns are reflected in statistics from the Local Government Association (LGA) showing that dental decay is the primary reason children aged five to nine are admitted to hospital in England. Such admissions rose by 14 per cent between 2010-2011 and 2013-2014.

A recent LGA report revealed the NHS spent a massive £35.3 million



changes to children's behaviours.

An international study involving 2,800 three and four-year-olds from 17 countries examined the degree to which parents' attitudes towards brushing twice a day and controlling sugar exposure impacted their children's oral health habits. It also examined the impact of factors such as ethnicity, culture, deprivation, and any previous decay experience.

Results showed widely varying attitudes in families from deprived and non-deprived backgrounds, and in families with and without caries. However it was the parents' perception of their ability to ensure brushing twice a day and control sugar snacking that was the most significant predictor of favourable habits being adopted.

Parental attitudes have been shown to be imperative in influencing their children's risk of developing decay, with some commonly held misconceptions and beliefs continuing to have a negative impact:

'Bad teeth run in the family'

'Some people just naturally have soft teeth'

'It wouldn't be fair to not give them sweets every day'

'They're only baby teeth, at least they'll get a new set'

'The dentist is the best person to prevent tooth decay in our child'

T DECAY

on dental extractions in under-18s in 2014-2015, a rise of 66 per cent since 2010-2011. It showed 40,970 procedures were carried out in 2013-2014 compared to 32,457 in 2010-2011.

This was blamed on high consumption of sugary drinks and food, prompting renewed calls for action.

The LGA's community wellbeing spokeswoman Izzi Seccombe said: "As these figures show, we don't just have a child obesity crisis, but a children's oral health crisis too. What makes these numbers doubly alarming is the fact so many teeth extractions are taking place in hospitals rather than dentists. This means the level of tooth decay is so severe that removal is the only option.

"Poor oral health can affect children and young people's ability to sleep, eat, speak, play and socialise with others. Having good oral health can help children learn at school, and improve their ability to thrive and develop, not least because it will prevent school absence."

Campaigners as diverse as TV chef Jamie Oliver and the British Dental Association have long called for action on excessive sugar intake. In 2013, the BDA launched its Make a Meal of It campaign calling for a 20 per cent tax on sugary soft drinks, a ban on unhealthy food advertising for children, removal of unhealthy vending machines in schools and hospitals, and restriction of junk food at shop tills.

The government appears to have finally responded with an announcement in the recent Budget of a levy on soft drinks companies based on sugar levels in their products.

Negative attitudes

While it's hoped measures such as a sugar tax will help, educating parents and carers in good oral health practice is key to making positive

Sending a message

There are numerous ongoing campaigns that aim to improve children's oral health across the UK, many run by the likes of the Oral Health Foundation, the BDA, and a variety of NHS and government agencies.

One of the most ambitious and wide-reaching is Childsmile, launched by the Scottish Government in 2006 with the aim of improving children's oral health and reducing dental health inequalities. It aims to reach every child in Scotland, offering free daily supervised tooth brushing at nursery; free dental packs for tooth brushing at home; and care with primary dental services.

Children and families in greatest need are supported directly through enhanced care from primary dental services, with additional home support as well as clinical programmes such as twice-yearly fluoride varnish applications for nurseries and primary schools

The scheme has been largely well received and since its launch, figures suggest children's dental health in Scotland is improving, particularly in deprived communities.

Budgets allowing, a nationwide prevention-based approach such as Childsmile could have a positive effect in the rest of the UK, perhaps helping to trim down the NHS' hefty teeth extraction bill.

What is clear is that the fight against child tooth decay needs to be a multi-faceted one, perhaps encompassing improved health education, national prevention programmes, targeted taxation, and tailored treatment for different patient types. With a bit of luck dentists will continue to see improvements and maybe one day children's oral health will really give us something to smile about.

Sameera Teli is a dentist and editor of SoundBite

DEPARTING FROM CLINICAL GUIDELINES

Following clinical guidance is not mandatory – but ensure you have good reasons for departing from recommended care pathways

KEEPING up with the latest clinical guidelines can prove challenging for even the most diligent healthcare professional, with new advice being released on what can often seem like a daily basis.

Bodies such as the National Institute for Health and Clinical Excellence (NICE) and the Scottish Dental Clinical Effectiveness Programme (SDCEP) are tasked with making recommendations based on the best available evidence of effective care. Other organisations also offer guidance on best practice including the Royal College of Surgeons and the Faculty of General Dental Practice (UK).

Dentists and other dental care professionals are expected to take this guidance into account when making clinical decisions. But is it ever appropriate for a practitioner to exercise their clinical judgement and choose to depart from such guidance? MDDUS advisers regularly deal with calls on this topic and advise doctors and dentists to exercise caution before departing from guidance.

Not the law

It is important to make clear that clinical guidelines are not legally binding and are intended to inform clinical practice rather than dictate it. NICE says its guidance is designed to help healthcare professionals ensure that the care they provide “is of the best possible quality and offers the best value for money”.

NICE goes on to say that its guidance “does not override the individual responsibility of health professionals to make appropriate decisions according to the circumstances of the individual patient in consultation with the patient and/or their guardian/carer”.

One example of a situation where a dentist could justifiably depart from accepted guidelines would be where a patient is likely to suffer an adverse reaction to a recommended dental material or drug. In these circumstances, it would be appropriate to prescribe an alternative. This also well illustrates the principle that no guideline can cover 100 per cent of patients because there are always variations and it is up to the clinical



professional to decide when a guideline is not applicable and what should be done instead.

On rare occasions you may even encounter conflicting guidance as in the current debate over the use of prophylactic antibiotics before dental procedures in order to prevent endocarditis in some at-risk patients. Here NICE guidance not to administer antibiotics in such circumstances is contrary to the view of the European Society for Cardiology which is in favour of their use.

Professional duty

The GDC is unequivocal that dentists are personally accountable for their professional practice and must always be prepared to justify their decisions and actions in regard to clinical guidelines. In its *Standards for the Dental Team* the regulator states: “You must provide good quality care based on current evidence and authoritative guidance. You must find out about current evidence and best practice which affect your work, premises, equipment and business and follow them. If you deviate from established practice and guidance, you should record the reasons why and be able to justify your decision.”

Practitioners thus have a professional duty to be aware of relevant guidelines in their field of practice and any decision to depart from these should be on a logical basis and justified

in the notes. In some cases, it may be advisable to seek the advice of a specialist or someone more senior before doing so.

Shared decision-making

The matter should also always be discussed in full with the patient, being sure to make them aware if your proposed treatment differs from standard practice. You should explain the reasons behind your decision and why you believe the proposed course of treatment is in their best interests.

A court will rely on expert evidence to determine what is “reasonable” practice and this will be regardless of whether a dentist followed guidelines. What is reasonable applies to both what the acting clinician judges to be so, as well as the patient. This principle was recently reinforced in a landmark legal ruling on shared decision-making and consent, *Montgomery v Lanarkshire Health Board*.

So in summary, carefully consider any decision to depart from clinical guidelines and be prepared to justify your actions. Always discuss any decision with the patient and record fully your reasons for departing from the guidelines. Should you be unclear how to act in particular circumstances ask a senior colleague or contact an MDDUS dental adviser.

Alan Frame is a risk adviser at MDDUS

PRESENTING THE FACTS



MDDUS dental adviser **Doug Hamilton** discusses the importance of telling patients about all viable treatments rather than focussing on one or two preferred options

CONSENTING can be a dynamic and somewhat subjective process: one man's explanation is another man's persuasion.

An advisory colleague uses a very effective means of demonstrating this reality to vocational trainees. He asks them to consider a scenario in which a new patient attends with an upper left 5 which has one foot in the grave and one foot on a banana skin.

He then divides the delegates into four groups and asks each to talk to this hypothetical patient with a view of securing consent to one of the following: a post crown, a dressing, an extraction or no treatment.

Without exception, these newly qualified dentists are able to rehearse a discussion that is perfectly reasonable and factually accurate, but which is framed in such a way as to maximise the chance that the patient will 'choose' the desired treatment for this dodgy premolar.

Clearly, this teaching model is designed to illustrate the importance of providing patients with comprehensive and neutral information. However, if we reflect carefully on our own consenting processes, many of us will acknowledge that the choices we offer may from time to time be a little selective.

Perhaps the manner in which we present these choices can be slightly slanted in favour of one particular treatment. We do this not because we wish to mislead our patients, but because we genuinely feel that certain approaches are second-best, too costly, excessively risky etc. So we perform a mental calculation and offer advice which emphasises the benefits of the option which we truly believe to be in that patient's best interests.

Usually we are ultimately proven right - we

are, after all, drawing on significant education and experience when assessing cases. Yet this justification misses an important point: it is really up to the patient to decide which (viable) treatments to accept and which to refuse and, in order to make this judgement, the patient needs to be given all relevant facts.

Those who doubt this premise need look no

"Alternatives, together with their own material risks, must be explained accurately and comprehensibly"

further than the General Dental Council's *Standards for the Dental Team* where registrants are required to "find out what your patients want to know as well as what you think they need to know", being sure to explain "all the relevant treatment options".

The legal system has also endorsed this doctrine in the recent Supreme Court ruling, *Montgomery v Lanarkshire Health Board*. Healthcare professionals are now required to treat their patients "...so far as possible as adults who are capable of understanding that medical treatment is uncertain of success and may involve risks, accepting responsibility for

the taking of risks affecting their own lives, and living with the consequences of their choices".

This requires dialogue, empathy and, not least of all, time. Patients must not be bombarded with reams of technical information. Discussion of material risks cannot be reduced to percentages. As GDC guidance states: "You must check and document that patients have understood the information you have given", and give them a "reasonable amount of time to consider that information in order to make a decision."

To be clear, this ruling does not require practitioners to carry out bad dentistry just because it has been requested by a well-informed patient. However, assuming the patient wants to be informed, all recognised alternatives, together with their own material risks, must be explained accurately and comprehensibly.

In short, an effort must be made to gain an insight into patients' wishes and the subsequent advice must be tailored to those wishes. To quote the Montgomery ruling, "...the assessment is therefore fact-sensitive and sensitive also to the characteristics of the patient".

In the midst of a busy session, the temptation to make a judgement call on behalf of your patient cannot be underestimated. However, this philosophy, irrespective of how well intentioned it may be, leaves clinicians vulnerable to criticism. The so-call 'prudent patient' test, long endorsed by the regulator, is now enshrined in law. Medical paternalism is truly consigned to history.

Doug Hamilton is a dental adviser at MDDUS

SURGICAL SOLUTIONS

Oral surgery promises a varied, challenging career that takes advantage of the latest technological developments

THE specialty of oral surgery is a dynamic one that has developed and evolved at a rapid pace in recent years. It has a key role to play in oral healthcare provision, particularly as dentists face growing challenges in treating an ageing population, with increasing numbers of patients retaining teeth later in life.

As the name suggests, oral surgery focuses on surgical interventions to address problems with the jaw and mouth. These range from the extraction of broken and decayed teeth to the removal of non-cancerous lumps and cysts, and the placing of implants. Career paths are broad-ranging and practitioners can work as specialists, or with a special interest in the field, basing themselves across both primary and secondary care. It has close ties with the specialty of oral and maxillofacial surgery but does not require a medical degree.

Technology has played a big part in advances in oral surgery and clinicians are increasingly able to use minimally invasive techniques. They can now take advantage of state-of-the-art innovations such as 3D cone beam imaging, digital impressions and other specialised computer programs.

Entry and training

Dentists interested in a career as a specialist in oral surgery are expected to have completed two years dental foundation training, or equivalent, with a minimum of two years dental core training in relevant posts. Following this, specialty training lasts three years (whole time equivalent), during the last six months of which dentists must successfully pass the specialty membership exam in oral surgery (M Oral Surg) of the Royal Surgical Colleges of Great Britain. Once they have completed training and passed the exam, they will then be recommended for a certificate of completion of specialist training (CCST).

Trainees working towards a CCST can gain experience in various settings, including a dental teaching hospital with relevant attachments in oral surgery or oral and maxillofacial surgery in district general hospitals, or specialist centres. They may also undertake formal postgraduate training, such as a Masters (M Clin Dent) in oral surgery offered by the likes of the University of Edinburgh and UCL Eastman Dental Institute, or the MSC/PGDip oral surgery programme offered by the University of Central Lancashire.

Once dentists have been awarded the CCST, they can choose to work as a specialist or pursue a two-year post-CCST development programme. This would also lead to an intercollegiate specialty fellowship examination and from there the dentist can work as an NHS consultant.

Dentists can also pursue an academic training pathway after completion of two years foundation training. This may initially be via an academic clinical fellowship post, followed by research training fellowship (PhD) and subsequent clinical lectureship, before leading back into the three-year core competency specialty training and postdoctoral studies. Ultimately this training can lead to honorary

consultant and combined academic (research and teaching) roles.

Dentists who plan to use the title of "oral surgeon" or "specialist" must successfully apply to join the General Dental Council's (GDC) oral surgery specialist list. This is not compulsory for working within the specialty. Many practitioners are not on the list and would generally be described as having a "special interest in oral surgery".

The job

The GDC defines oral surgery as dealing with "the treatment and ongoing management of irregularities and pathology of the jaw and mouth that require surgical intervention. This includes the specialty previously called surgical dentistry."

Specialists spend much of their time dealing with the surgical aspects of patient care that go beyond the competence of general dental practitioners. Work can be based both in primary and secondary care with common procedures including:

- complex dental extractions
- apical surgery
- implant placement
- dealing with minor trauma, carried out under local anaesthetic with or without sedation in a primary care setting
- dealing with more complex patients or major surgery requiring general anaesthetic in the hospital service.

Practitioners can take advantage of the latest techniques which allow jaw surgeries to be planned in 3D with the use of CT scans and specialist computer programs. Detailed digital reconstructions of the face and skull can be made easily, which has improved the way implant surgeries are carried out. Procedures can also be carried out virtually on a computer, allowing the oral surgeon to practise skills to assist in hands-on patient care.

The British Association of Oral Surgeons provides useful resources and professional networking/educational opportunities for practitioners, from those with a special interest to specialists and academic oral surgeons. Annual membership costs £125 and includes access to their *Oral Surgery* journal.

Sources

- Royal College of Surgeons of England, Faculty of Dental Surgery. *Specialty training curriculum: Oral surgery* - <http://tinyurl.com/zrap39y>
- British Association of Oral Surgeons: www.baos.org.uk

"I find great satisfaction in being able to remove a tooth and alleviate a patient's pain"

Q&A

Rachel Evans is a dentist with a special interest in oral surgery

• What attracted you to a career in oral surgery?

I was initially simply keen to further my expertise in removing teeth and gain further surgical skills. I undertook my first job as an SHO in oral and maxillofacial surgery and absolutely loved it. I never went back to general dentistry and carried on with a career in oral surgery.

• What do you enjoy most about the specialty?

I personally now work in several different settings from private general dental practice to my local oral and maxillofacial surgery department, providing a minor oral surgery service and a two-week-wait cancer screening clinic. I have great support from all of my dental colleagues in practice and in the hospital. I love the diversity of my job, as I never really know what to expect from each day. During my time as a staff grade in oral and maxillofacial surgery I loved operating on facial trauma patients out of hours, repairing facial lacerations and plating fractured mandibles. I miss my trauma operating time, but now enjoy more sleep and a regular 9-5pm job.

• What do you find most challenging?

I find great satisfaction in the ability to remove a tooth and alleviate a patient's pain and anxiety. Yet one can never be complacent as teeth are unpredictable and you can still be caught out, even with 10 years of experience. So taking out teeth still keeps me on my toes. It

gives me a sense of achievement when all goes well and the patient leaves with a smile on their face.

• Have you been surprised by any aspect of the job?

I still find it slightly daunting to remove teeth from children under local anaesthetic. They are unpredictable, yet often I am surprised at how well some of them cope. It is essential to gain the trust of a patient. Children are very perceptive so if they think you are hiding something, they will remain suspicious. I find being honest and taking the time to explain what is going to happen, the best strategy. I have actually even had adult patients fall asleep while I remove multiple teeth... and that is without sedation!

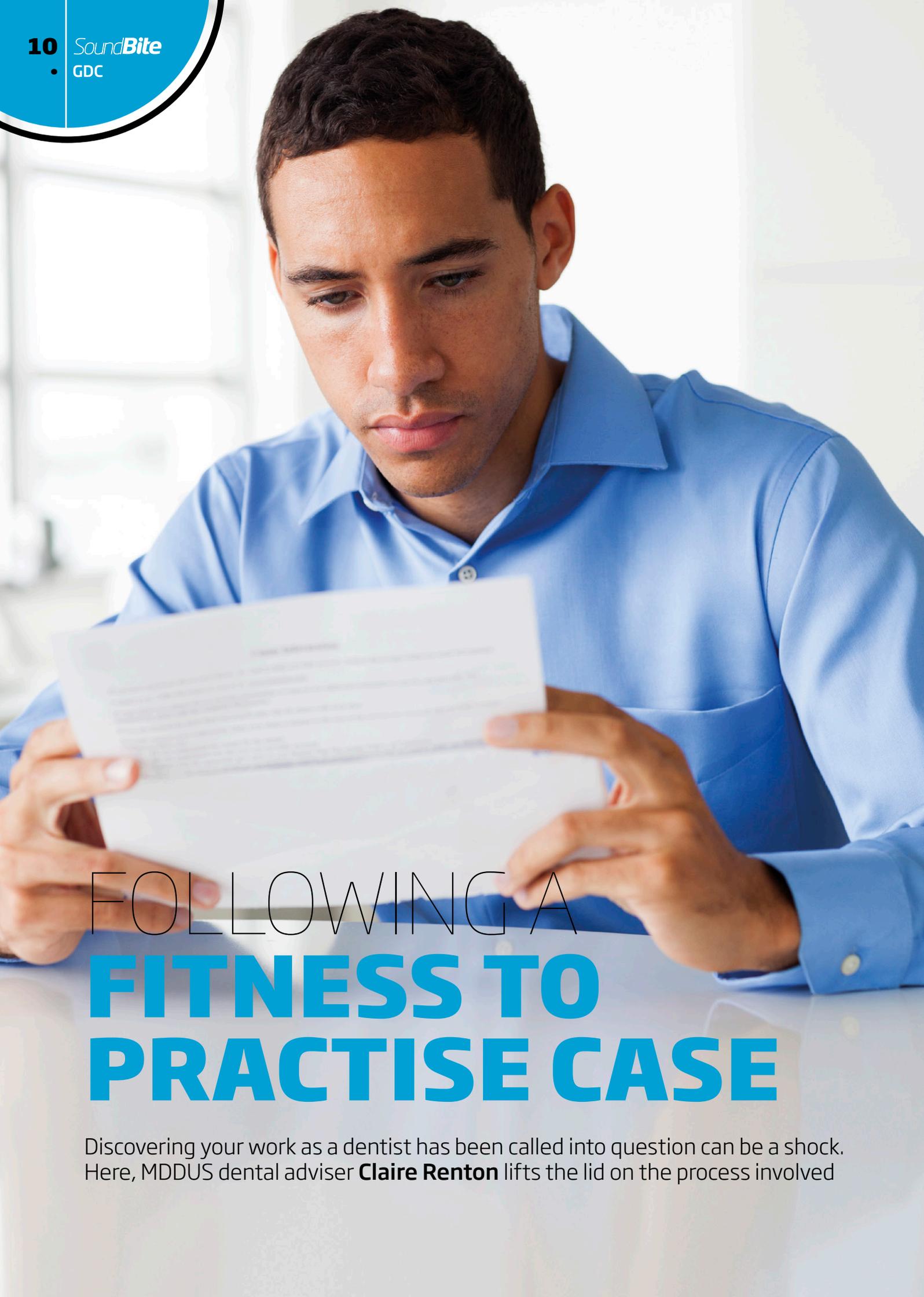
• What personal attributes do you feel are important in oral surgery?

Empathy is a great personal attribute to have as an oral surgeon. Our patients don't want to be sat in the dental chair and they certainly don't really want to be having a tooth pulled out. If you are able to understand the patient's anxieties and then provide reassurance, your patient will be so much more cooperative.

• What advice would you give to a student or trainee considering the specialty?

Go for it! I have never regretted my decision. Oral surgery offers a great future for anyone with a sense of adventure. There are real opportunities for professional growth and hopefully in time, the number of training posts will increase. I would encourage individuals to engage with the BAOS (British Association of Oral Surgeons) and their local specialists, to gain an insight into the job and the many job opportunities available to an oral surgeon. The BAOS annual conference offers the opportunity to hear some fantastic lectures, as well as the chance to present posters on subjects within oral surgery. Poster entries are considered for prize awards and are an asset to any CV for an individual keen to apply for further training.



A man with dark hair, wearing a light blue button-down shirt, is sitting at a white desk. He is looking down at a white document he is holding with both hands. The background is a bright, out-of-focus office setting with a window. The text 'FOLLOWING A FITNESS TO PRACTISE CASE' is overlaid on the bottom half of the image.

FOLLOWING A FITNESS TO PRACTISE CASE

Discovering your work as a dentist has been called into question can be a shock. Here, MDDUS dental adviser **Claire Renton** lifts the lid on the process involved

AN OFFICIAL-LOOKING letter lands on your doorstep and its first line reads: "I am writing to tell you that we have received some information about you which we are currently reviewing."

That's the opening sentence in the correspondence that the GDC send when they are starting a "fitness to practise" investigation. It's heart-sink stuff; it will take your breath away and is the start of a journey which can make you wish you had never thought of becoming a dentist in the first place. It may follow on from an unresolved patient complaint or it might follow from a health board or LAT investigation. It might also be completely out of the blue.

Horribly, it might even follow a dispute with a colleague, often over non-clinical matters, who realises there's nothing like alleging you are not fit to practise to cause maximum damage. We have dealt with cases where dentists have sent screen shots of errors on their competitors' websites to the GDC. We've also assisted dentists who have sold their practice and the incoming dentist has trawled through dental records to find a missing BPE or ungraded X-ray suggesting that the retiring chap is not fit to practise. Often, these disputes are fuelled by financial rather than patient safety motives but if a complaint is received at the GDC, they must investigate.

Get in touch

So, if you are unlucky enough to receive this letter from the GDC what should you do? Well two things: the first is get in touch with us as soon as you can. We are very familiar with GDC processes and we will support and assist you.

The second thing is to relax and stop panicking, then thank your lucky stars that you chose indemnity and not insurance for your cover for clinical practice. Why? Well, if you are with MDDUS you can be sure that a dental adviser will be allocated to you, and appropriate lawyers, experts and barristers will be engaged should you need them in order to protect your position. All the expense associated with this is covered by your indemnity provision and there is no cap on our expenditure. In other words, you will get everything necessary to support you.

I know that early in our careers we can feel invincible and that this will never happen to us, but lots of good dentists find themselves under the GDC's scrutiny these days and it's not until you are in that position that you appreciate the importance of indemnity cover. Compare that to simple insurance with a fixed cap for GDC cases and you'll soon relax.

GDC pathways

There are a number of routes a GDC investigation can take. If the allegations are serious and, if proven, would show you are potentially unsafe or dishonest then an interim orders committee can be convened to assess whether restrictions need to be placed on your registration during the investigation. This usually happens within a week or so of your receiving the correspondence so it's important to get in touch with MDDUS quickly. An interim orders committee might be convened in private if there are health issues to be considered, such as alcohol or drug dependency or

a mental health issue which could affect patient care.

Most cases however trundle along at a much slower pace. Once the GDC have been given the clinical records they are sent off to a GDC expert who makes a judgement on the quality of the care provided and, yes, you're way ahead of me, the quality of the records too! Once assessed, the GDC decide if there is a case to answer and, if so, an investigating committee is convened. Allegations are sent to the dentist along with a copy of the GDC's expert witness report. We are usually given around four weeks to write a response to these allegations.

The investigating committee meets in private and our response to the allegations is made in writing. The committee has a number of options for disposal of cases. It may decide that there is no case to answer; it may issue the registrant with a letter of advice or a letter of warning which may be published on the GDC register; or worst of all it may refer the case to a full fitness to practise hearing.

These take place in London and are run along the same lines as a court hearing where the GDC will engage lawyers and a barrister to make the case against the registrant. Scary stuff indeed, but don't fret as we will have our full expert team of in-house lawyers and a barrister to defend you and offer advice and support at every stage.

Peace of mind

Unlike a criminal court where sanctions (jail/fines/community service etc) are applied depending on the nature of the crime, at a GDC hearing the panel is obliged to assess if you are currently impaired or if you are currently fit to practise. This is regardless of whether you have a past finding of misconduct for your care of the patient. Sanctions are only applied if you are *currently* impaired. Not surprisingly then a lot of time is spent by the MDDUS advisory teams ensuring that by the time your hearing date arrives

you are absolutely fit to practise and your record keeping is up to scratch. We will also ensure you can demonstrate that any deficiencies have been remediated, and that you have properly reflected on any failings.

A GDC investigation is potentially a harrowing experience, with concerns about job security and the possibility of adverse publicity. However, cases rarely turn out as badly as the dentist fears. The team here at MDDUS are experienced in GDC work, we achieve good outcomes for our members and are here to support and provide guidance through unfamiliar territory at every step of the way.

Of course the best thing is to do all you can to avoid things escalating to the GDC. Do all you can to resolve complaints quickly and effectively, fully assess and treat your patients as if they were a beloved relative, refer to a specialist if you are in doubt, and keep meticulous records. Easy, eh? Oh and one last thing: if you fall out with a colleague, don't refer them to the GDC unless patient care is really in danger. After all, how else will we be able to keep the GDC's annual retention fee down if we provide them with inappropriate cases to investigate?

"Relax and stop panicking, then thank your lucky stars that you chose indemnity for your clinical practice cover"

Dentist Nick O'Donovan talks about his work offering treatment to the needy in an innovative new scheme that asks for only "as much as you can afford"

THE JUNK TOOTH A DENTIST

WHEN the working day is over, and the last patient has left the surgery, a queue starts to form outside Nick O'Donovan's practice. That's because the Dewsbury dentist reopens half-an-hour after closing to treat more patients - ones that do not have access to an NHS dentist.

It's part of a successful pilot, The Real Junk Tooth Project, which has just celebrated its six-month anniversary and now looks set to be extended to other parts of the UK.

In partnership with international dental charity Dentaid, the project offers a pay-what-you-can-afford emergency dental clinic to homeless people and others who struggle to access dental care because of language, distance, or low income, during a two-hour drop-in session once a week. Dentists and other staff offer their services on a voluntary basis.

Its launch in December 2015 followed a 2011 study that found 98 per cent of homeless people in the UK experienced dental decay.

Giving back

For Nick, principal at Dewsbury Dental Centre, it is an opportunity to give something back.

He says: "Dentistry, fortunately or unfortunately, is a business. We're often accused of putting business before patients. But we are putting patients before business.

"When we go to university as dentists, we might say we do it for the money, but we do it because we want to help people. The money is good, but I have the facilities to help people out-of-hours and volunteering for two hours on a Thursday evening is not too much to ask."

The Real Junk Tooth Project (RJTP) is a spin-off from food waste charity, The Real Junk Food Project, which collects out-of-date supermarket food for homeless people. Staff working on the project found that many of the

service users had poor dental care and, often because of dental pain or rotting teeth, couldn't eat the free food.

That's when Nick came on board to donate his time, staff, and his premises.

To date, the Dentaid-supported RJTP project has treated 115 patients. Of those, the vast majority were male (63 per cent compared to 36 per cent women), aged 45 and over (30 per cent), with most patients visiting the project after struggling to access NHS dental care.

The Dewsbury dentist says he "jumped at the chance" to be involved with the charity that



is best known for its work in developing countries: "Dewsbury does have its problems as a town, it has poverty issues, so when someone says to me that people are going to a food charity but cannot eat their dinner because their teeth are hurting them, I want to help.

"We are not offering root canal, we are just offering basic pain relief and we will remove their rotten teeth. And people are very grateful for it. My regular patients think it's brilliant - not one has asked me 'why are you doing that?'

"It doesn't cost much - the biggest cost is the staffing but my nurses have all volunteered their time. I have been amazed by the number of people who have volunteered.

"And the materials cost virtually nothing -

take the amount of local anaesthetic I have used during this project, for example, I have probably spent the same on the wife during a night out in Leeds!" he laughs.

The Real Junk Tooth Project is not the first volunteer role that father-of-four Nick has taken on. The experienced dentist has been to Malawi before and is set to return to the southeast African country in April 2017.

He added: "I have seen what it is like where there are no dentists at all when I went to Africa with Warm Heart Malawi. There I had a waiting room of 90-100 people. I pulled out more teeth in a week there than I could have ever imagined."

Nick could not have offered this vital 'pay as you feel' service back home if it wasn't for the support from Sue Baker of Yorkshire and Humber Deanery and the vocational trainees she has provided who also volunteer on the project.

He says: "We have had a couple of VTs volunteering each week since the project started, some are DF1 and some are LDF2. They are always supervised by a VT trainer or an experienced dentist to make sure they are alright and don't get into any trouble. The foundation dentists have been very good."

Big uptake

Given Dewsbury's poverty issues, the uptake amongst local people unable to access emergency dental care has been huge.

Nick explained: "I finish my regular general practice surgery at 5.30pm, and we start up at six o'clock. They are usually queuing outside the door from 5.45pm.

"Last week we had 10 patients, which was quite busy when they all need extractions - and they usually need more than one tooth out. Most of these patients are not interested in regular check-ups, but don't want their teeth to hurt them, and they are no less-deserving than the patients I see regularly."

PHOTOGRAPHS: DENTAID/NICK O'DONOVAN



Clockwise from main picture: Nick O'Donovan at his practice; Clare Skipper, who resorted to pulling her own tooth out with a pair of pliers; Nick volunteering at a dental clinic in Malawi

A review of the service shows most patients have either a single (48 per cent) or multiple extractions (13 per cent). One of the first patients to benefit from the scheme was Matthew Phillips who had a wisdom tooth removed. He said he'd been "in pain for months" but couldn't get an NHS dentist to see him and admitted: "I can't sleep, it's affecting my whole life. Without toothache my life will be much better."

Claire Skipper, 29, sought help after pulling her own tooth out with a pair of pliers.

She says she's been unable to find a practice accepting NHS patients, adding: "I dread something going wrong with my teeth again. I can't afford to go on a private care plan - sometimes we don't have enough money for the electricity meter. No one in Britain now should have to resort to pulling out their own teeth and it's fantastic that these dentists care enough to help."

As well as the community benefit, dentists in surrounding areas have benefited by extending their professional network, says Nick: "As dentists, we are often very insular, but now we are all talking to one another a lot more than we would have done. I now know dentists who have been working in the next town for 15 years."



"No one in Britain should have to resort to pulling out their own teeth and it's fantastic that these dentists care enough to help"

The future

Now, six months after the pilot was launched, Dentaïd hopes to extend the scheme to other parts of the country and increase access to emergency dentistry by working with the NHS.

The charity's strategic director, Andy Evans, recently met with the Chief Dental Officer Sara Hurley to discuss the scheme's future.

Andy says the scheme is about "breaking down barriers" and enabling more people to access dentistry.

"We want to help the people who are falling through the gaps - to stop them self-medicating, extracting their own teeth or trying to live with long-term dental pain," he says.

"We know the NHS does a wonderful job but some people are still missing out and they are often those with the greatest dental needs. We're very excited about the prospects for this project as it moves forward."

To find out more about The Real Junk Tooth Project, including how to volunteer, contact Dentaïd on 01794 324249 or email info@dentaïd.org

Kristin Ballantyne is a freelance writer based in Glasgow



DAY ONE

Mr T attends his dental surgery complaining of pain in his lower left canine tooth. The dentist - Mr R - notes a sinus draining from the apex of the tooth and a radiograph shows that it is non-vital. Mr R opens the tooth and dresses it with creophene and cotton wool as a temporary measure and asks the patient to make a longer appointment for root canal treatment (RCT).



DAY 30

The treatment on LL3 is completed without complications. The patient is advised to return to the surgery if he experiences any pain or swelling.



DAY 33

Mr T attends the surgery with pain and numbness in the LL region with swelling spreading under the tongue and difficulty swallowing. An abscess is noted at LL3 and Mr R advises that it should be incised. Mr T agrees and the dentist administers a local anaesthetic and proceeds to incise the abscess with a scalpel, releasing superficial pus. The patient is given a prescription for an antibiotic (amoxicillin).



DAY 40

The patient telephones the surgery to say that he is still suffering numbness in the lower left lip and some swelling. The dentist advises Mr T that paraesthesia is not uncommon and should resolve within two weeks, along with the swelling. He prescribes further amoxicillin.



ONE MONTH LATER

Mr T returns to the surgery still complaining of numbness in his lip and is seen by the dentist who says it may take up to a few months more for sensation to return to normal. The dentist makes a note in the record to consider removal of the root canal treatment if the numbness has not resolved.

OVER a year later the dentist receives a letter of claim for damages in regard to his treatment of Mr T. It is alleged that the dentist did not tell the patient about the clinical risks associated with incising the abscess at LL3 and thus consent was not informed. Nor were the risks discussed for local anaesthesia involving nerve block injections. Mr T has stated that had he known of the attendant risks he would not have agreed to the procedure.

In regard to the incision it is alleged that the dentist failed to take into account the anatomical course of the mental nerve and during treatment cut it or some of its fibres. The letter also claims a breach of duty in care for failing to refer Mr T to an expert maxillofacial surgeon for drainage of the abscess and later when it became clear that the paraesthesia was not resolving.

The letter states that due to the dentist's negligent treatment the patient is now left with permanent loss of sensation, requiring referral to a dental neurological specialist for further treatment.

MDDUS advisers assess the associated case papers and commission a report from an expert in oral and maxillofacial surgery. In the expert's opinion the nerve injury is permanent given the period of time now passed without significant improvement.

Four theoretical causes of the injury are considered in the report. The expert rules out injury during the root canal treatment because of the position of the mental nerve relative to the apex of the canine tooth. He also believes it is unlikely that local injection prior to the RCT could have led to the nerve injury. Infection could have also caused altered sensation but again the position of the nerve relative to the tooth makes this unlikely.

The expert expresses the opinion that the paraesthesia most likely resulted from the mental nerve being cut when the dentist was incising the abscess, but such a complication would not in itself be negligent. He states that it is easy to damage these nerves as they lie just below this mucosa in the buccal sulcus. He also notes that the patient is clear in his evidence that the change in character and perception of the sensation was quite distinct after the incision. The crucial issue is the lack of any evidence in the patient records that the risks of the procedure were discussed.

Considering these vulnerabilities in defending the claim MDDUS lawyers decide with agreement of the member to settle the case.

Key points

- Ensure that relevant risks in any procedure are discussed with patients.
- Discussions with patients in regard to consent should be recorded routinely in the notes.

OUT THERE

FEAR FACTOR Twelve per cent of UK adults would rather hold a tarantula than visit the dentist according to YouGov research. A third of people who have ever visited the dentist said they felt scared beforehand, with the top deterrents being potentially undergoing a dental procedure (31 per cent) and fear of needles/injections (30 per cent). Lack of trust, relinquishing control, and the unknown were among the fear factors highlighted.

BUG KILLERS Dutch researchers at the University of Groningen say they have found a way to create 3D-printed teeth that kill bacteria without harming human cells. They told *New Scientist* they could embed antimicrobial quaternary ammonium salts into existing dental resin polymers. The bacterial matrix was then used to print various dental objects. They hope the tech will be ready for clinical use after testing.

DENTAL RECORD Mumbai surgeons extracted a record-breaking 232 teeth from the mouth of a 17-year-old boy in a seven-hour operation. He had severe pain for 18 months and was diagnosed with a very rare complex composite odontoma, a type of benign tumour where a single gum forms lots of teeth. The boy is now pain-free and has 28 teeth.

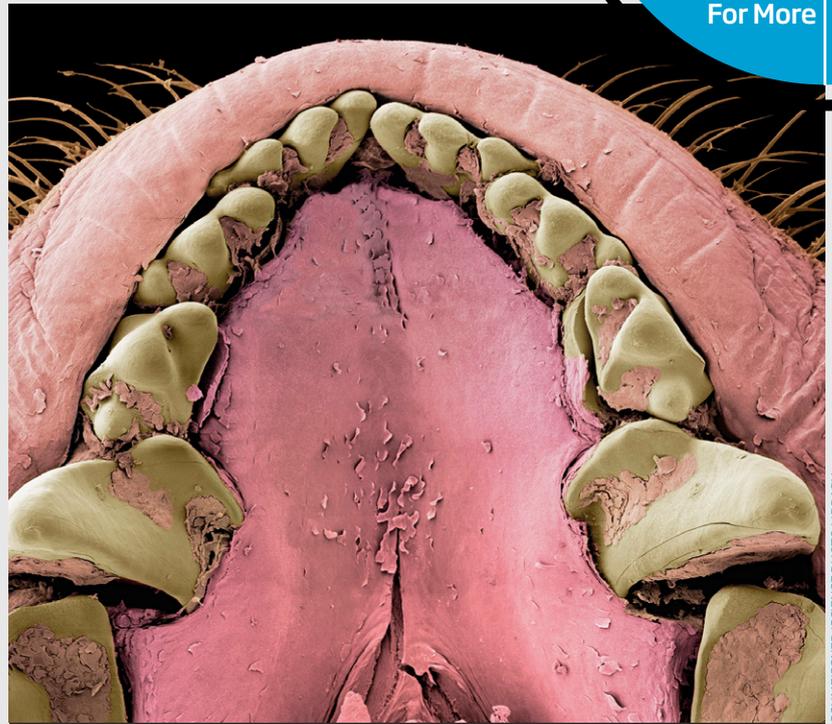


PHOTO: STEVE GSCHEISSNER/SCIENCE PHOTO LIBRARY

NAME THAT BITE
Stumped? The answer is at the bottom of the page

CROSSWORD

ACROSS

1. Dandies (4)
3. Residue (8)
9. Canadian territory (7)
10. Singular data (6)
11. Opportunist robbery (5,3,4)
14. Connects to bolt (3)
16. Events in the diary (5)
17. Draw (3)
18. Loving exchanges of tongues (6,6)
21. Florida city (5)
22. Inserted into cavity (7)
23. Hole or gap (8)
24. Evaluates (4)

DOWN

1. Cleaning between the teeth (8)
2. Flatbread (5)
4. Self esteem (3)
5. Likely to cause a stomach ache? (12)
6. Remove tooth (7)
7. Weighty book (4)
8. Specialist in the straightening of teeth (12)
12. Incision on an edge or surface (5)
13. Communications (8)
15. Sauce, calculus finds ecstasy (7)
19. A dentist's reward? (5)
20. Organisation endorsed by Village People (abbr.) (4)
22. Animal hair (3)

1		2			3	4		5		6		7
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See answers online at www.mddus.com. Go to the Notice Board page under News.

Online risk tools

Healthcare is a risky business... and to help you mitigate your own risks MDDUS Risk Management is working to develop **FREE** new and innovative tools for members and their teams.



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