



MEET THE DENTIST HELPING ELITE ATHLETES

SPORTING **CHANCE**

ALSO INSIDE

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KNOW THE RISKS

AN MDDUS
PUBLICATION



UK INDEMNITY, ADVICE & SUPPORT



Welcome to your **SoundBite**

THE concept of candour is one all dentists should be familiar with. But do you know the difference between your professional duty and your statutory duty? Dental adviser Sarah Harford explains on [page 6](#).

Patients who identify as lesbian, gay, bisexual or trans (LGBT) often have complex health needs that can increase their risk of oral health issues. Building trust is key and it is crucial that practices provide a safe and inclusive environment. Find out more about caring for this patient group on [page 10](#).

As public awareness of orthodontic treatment increases, many general practitioners now provide a range of options. Specialist Robbie Lawson advises how to avoid key clinical risks when dealing with both adolescent and adult patients ([page 8](#)).

Dentistry can be a stressful job but dental business coach Alun Rees has some useful techniques to improve resilience and beat

burnout on [page 4](#). He recommends taking control of your appointment book and never taking work home.

NHSE dental adviser Dr Nishma Sharma reflects on her career so far and highlights her top tips for new dentists on [page 5](#). Key to success are trusting your team, following your instincts and most importantly taking care of your own physical and mental health.

For elite athletes, looking after their teeth may not top their list of priorities. But Dr Julie Gallagher believes it should be. The dentist and keen triathlete discusses her fascinating research into the link between athletes' oral health and their performance on the field ([page 12](#)).

Our case study on [page 14](#) looks at a wrong-site extraction following an alleged failure to carefully assess a patient's radiograph.

• **Doug Hamilton**
Editor



NEW GUIDANCE ON REMOTE PRESCRIBING

NEW guidance on remote consulting and prescribing has been published by 13 healthcare organisations, including the GDC.

The guidance sets out "high level principles" of good practice designed to safeguard patients who access medical and dental care online, via video link or by phone.

Among the key points, it states that healthcare professionals with prescribing responsibilities should:

- understand how to identify vulnerable patients and take appropriate steps to protect them
- carry out clinical assessments and medical record checks to ensure medication is safe and appropriate
- raise concerns when adequate patient safeguards aren't in place.

The principles apply to all those involved in providing consultations and medication to patients remotely, including doctors, nurses, pharmacists, dentists and opticians.

GMC chief executive Charlie Massey, said: "These principles will remind all healthcare professionals of the importance of prioritising the safety and welfare of patients when prescribing medication remotely, and will help facilitate a culture where unsafe practice is called out and acted on."

The principles were welcomed by MDDUS joint deputy head of medical division Dr Susan Gibson-Smith. She said: "It is reassuring to see healthcare regulators and organisations reinforce the need to mitigate against the risks associated with clinicians treating patients remotely when they have little or no access to their medical records.

"For example, contact with vulnerable patients requires a heightened level of awareness, as in our experience issues can arise if safeguarding clues are missed during remote consultations, or when arrangements for following up with the patient are not adequate."

She added: "We are also reassured that the principles advise UK-based healthcare professionals on important considerations should they be asked to provide remote services to patients abroad, emphasising the potential indemnity and regulatory difficulties with this."



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SOUNDBITE TO BE RELAUNCHED AS INSIGHT - DENTAL

THIS will be the last issue of MDDUS' twice-yearly *SoundBite* magazine. In May 2020 we will launch a quarterly *INSIGHT - Dental* via the premium digital magazine platform Foleon. This move is part of a larger strategy to reduce our print/postage costs to members and reduce our environmental impact.

We will also be publishing two additional quarterly titles aimed at primary care and secondary care (replacing our current suite of magazines). These publications will cover all the topic areas found in our existing titles and more - with targeted content appealing to a wider range of members.

All the *Insight* titles will be distributed via an email link, but those existing members who previously opted for print will still receive a hard copy in the post.

DENTAL FACULTY GUIDANCE GOES ONLINE

KEY guidance for dentists and their teams has been made available for free online.

The Faculty of General Dental Practice UK (FGDP(UK)) has published *Standards in Dentistry*, its comprehensive collection of standards and guidelines for primary care dentistry.

Acting as a guide to personal or practice-based quality assessment, it sets out specific basic and aspirational standards.

Areas covered include:
emergency dental care,
examination and record-keeping,
infection prevention and control,
medical emergencies, medications
management, oral health,

pathology, patient information,
practice management, prevention,
radiography, restorative dentistry,
risk management and
communication, sedation, special
care dentistry and staff training.

Access the guidance at:
www.fgdp.org.uk/guidance-standards



EARLY PREVENTION BEST OPTION IN CHILD TOOTH DECAY

A MAJOR three-year dental study of children has found no evidence to suggest that any one of three accepted treatment strategies was better than another in stopping pain and infection from ongoing decay in primary teeth.

Dentists involved in the study recruited over 1,140 UK children with visible tooth decay between the ages of three and seven. One of three treatment approaches was then chosen randomly: conventional fillings, sealing decay into teeth, and using prevention techniques alone, such as reducing sugar intake, twice-daily brushing and application of fluoride varnish. The children were then followed for up to three years.

No evidence was found to suggest that any one of the treatment strategies was better than another in terms of making a difference in children's ongoing experience of pain or infection, quality of life or dental anxiety between groups.

Professor Nicola Innes, Chair of Paediatric Dentistry at the University of Dundee and lead author on the paper published in the *Journal of Dental Research*, said: "Our study shows that... children who get tooth decay at a young age have a high chance of experiencing toothache and abscesses regardless of the way the dentist manages the decay." She added that prevention remained the best way to manage tooth decay.

SNOMED CT REMINDER FOR DENTAL PRACTICES

ALL electronic systems used in the provision of NHS services are expected to employ the terminology SNOMED CT as of 1 April 2020 - and this includes dental practices.

SNOMED CT is a structured clinical vocabulary used in electronic health records and is an international standard.

The Health and Social Care Act 2012 mandates that systems involved in the care of individuals in dentistry in England must use SNOMED CT for patient record keeping, electronic communications and data capture.

This includes all practices that hold an NHS contract and any provider that does or may interact with the NHS for the provision of a course of treatment.

TOOLKIT FOR SAFEGUARDING CHILDREN WHO MISS APPOINTMENTS

A NEW toolkit has been launched to support the safeguarding of children and young people who miss dental appointments.

The approach marks a move away from the "did not attend" pathway towards one that recognises children often have no control over whether they attend appointments.

The "was not brought" pathway - WNB-CYP - was published in the *British Dental Journal* and is available for all dentists and their teams to use via the BDA website.

The toolkit provides a step-by-step guide to managing the pathway in dental practices. It offers a flowchart for action and downloadable template letters to help the team follow a standardised approach which will keep young patients safe. It will help practices to identify at each stage of the process, which other healthcare professionals they need to communicate and share information with if they

are worried about patients facing dental neglect.

Charlotte Waite, Chair of the BDA's England Community Dental Services Committee, said: "For many health professionals treating [children] the term "did not attend" has never been applicable. This 'was not brought' toolkit is designed to help the whole dental team, and provide practical help on making this important distinction."

The framework is designed to support any healthcare professional treating children and young people, Access at: www.bda.org/safeguarding



RESILIENCE IS A HABIT

STRESS is defined as a non-specific response of the body to any demand. Without it we couldn't function. But when it turns excessive and becomes "distress", we can't function either.

The great endocrinologist Hans Selye coined the word "eustress", which he described as good or happy stress. Examples would be excitement at starting a new job or an upcoming wedding. Mild stress is needed for motivation and spurring us into action. Without it none of us would start, let alone get through, a day of clinical dentistry.

Dentistry is hard and not everybody is suited to it emotionally, mentally or physically. It can be a lonely place. Being a medical professional brings a lot of pressures, not least having to make quick decisions, often with a finite time to complete procedures.

Being a business owner is lonely too. Dentists are notoriously poor leaders, and often micro-managers, who are poor at delegating. They have problems making business decisions in a dispassionate way, and often prefer to do more clinical work rather than work on their business.

However, with fewer owners the consequently increased numbers of associates can feel they have little or no input into the way that they work. This perceived or real loss of control only adds to stress levels. Add the behaviour of the General Dental Council (GDC), NHS austerity and increased external compliance and the weight becomes heavier.

Too much stress results in the phenomenon of "burnout", recently recognised in the International Classification of Diseases and defined as: "A syndrome conceptualised as resulting from chronic workplace stress that has not been successfully managed."

It is characterised by three dimensions:

- Feelings of energy depletion or exhaustion
- Increased mental distance from one's job, or feelings of negativism or cynicism related to one's job
- Reduced professional efficacy.

Writing in the *Harvard Business Review*, Monique Valcour described some of the consequences of burnout. These include coronary disease, hypertension, GI problems, depression, anxiety, increased alcohol and drug use, marital and family conflict, alienation, a sense of futility and decreased career prospects.

Bouncing back

Resilience is the ability to recognise, control and recover from stress in ourselves and others before it leads to burnout. We are familiar with the concept from dental materials science

Dentistry can be a stressful job but dental business coach **Alun Rees** offers practical advice on how to become more resilient

when it is defined as the ability to bounce or spring back into shape or position. A current buzzword, "bouncebackability", sums it up pretty well.

We all know people who seem to take everything in their stride and are rarely, if ever, put out by events, changes or unforeseen occurrences. How do they do it? Is it a natural instinctive talent or something that can be learned?

The more resilient individuals are often those who have looked over the edge and stepped back. They have taken as much control over their lives as they can and they have identified what is important to them. They know what they can control and learned to accept what they cannot. They understand that "this too will pass". Dental teams are always told to "know your patients", but it is vital that they know themselves too if they are to get the best for both.

Below are some useful techniques to consider incorporating into your daily practice:

1. Good sleep habits, nutrition, exercise and connection with people you enjoy being with are a good start. It is easy to become isolated in our own little silos if allowed

2. Habits and routines that promote calmness and wellbeing including meditation, journalling and enjoyable quiet time all help
3. Some of the most important work that I do with my clients is to help them take control of their appointment book. A useful and practical exercise is to analyse your working week and see what times or activities are causing the wrong type of stress. Print your day list and go through it with a highlighter: green, yellow and red for good, moderate and bad times. What can you do to change this? What's stopping you?
4. Great advice I was given: "wipe your feet mentally on leaving surgery and avoid taking work home"
5. Get a coach to help you reassess your life and work. Is this a blip or a long-term challenge? Are you in the wrong job or even in the wrong career? Are you capable of changing things? Is it the work or is it you that needs to change?

To quote Monique again: "There is no job that's worth your health, your sanity, or your soul. For many people, burnout is the lever that motivates them to pause, take stock, and create a career that's more satisfying than what they had previously imagined."

Alun K Rees BDS is The Dental Business Coach, an experienced dental practice owner who works as a coach, consultant, troubleshooter, analyst, speaker, writer and broadcaster.
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MOVING ON UP

Dr Nishma Sharma offers advice to dentists taking the next step in their careers



THE move from the safe environment of dental school to the world of VT (now foundation training) was momentous, and second only to that from VT to OMG-I'm-actually-on-my-own associateship.

I remember it well. Going from a handful of patients per day to 20 seemed impossible, but after a few weeks I thought "I can do this!"

We come out of dental school thinking that we are dentists, and of course we are theoretically. We are definitely competent, but what makes a capable dentist? One who doesn't panic before an ominous 'pain' patient and who knows how far to challenge herself?

Trust your team

During VT, I was lucky enough to have an excellent trainer and experienced nurse. Although I was technically in charge in that room, it was my nurse who guided and supported me when things got hairy. The dentist/nurse relationship can be tricky to establish but it is invaluable. As a young female, I worried about how to assert authority without seeming arrogant or "bossy". But thankfully it does get easier with experience. I learned to keep clear boundaries between my professional and personal lives, and to be fair, consistent and respectful. Having a BDS does not make you superior: quality patient care depends on the whole dental team working together.

Trust your instincts

All dentists should reflect carefully on their skill set and know the limits of their competence. So if we feel that a particular treatment we are being asked to perform either isn't appropriate or is beyond our competence, then I feel it is important to say "no". If you do not think that you are capable, comfortable or correct in doing something, do not be bullied into it. You are the

clinician and you must act in your patient's best interests. If you do not feel it is the right decision, don't do it (and refer to a specialist where appropriate). Never be swayed by financial gain, pride or hubris. If in doubt, seek advice from a more experienced colleague or trainer.

Practice makes patients

Remember that every dentist will develop at their own pace. So what if your mates are all now seeing 20 patients a day and you're still struggling to get through a prep in 50 minutes? Take your time. Practise everything. While you shouldn't act beyond your competence, equally don't refer out every tricky procedure or you will struggle to improve. If you're cutting corners, you're not speeding up, you're just missing out steps which could be the difference between a treatment succeeding or having to do it all again, leading to more stress for everyone. Those hours of practice will pay off and your confidence will naturally attract more patients and more challenging cases.

Shift focus

If your reason to be in this game is to buy a Ferrari in the first year, I have some disappointing news. There are far easier and less stressful ways to make money! While you will make a good living, that shouldn't be your sole motivation. It won't sustain you long term. Change the narrative so that you focus on the huge satisfaction of being a healthcare professional who helps patients. "Cash in" on the joy of somebody recommending you or sending a thank you card, rather than how much "upsell" they agreed to. If your patient's wellbeing is at the heart of every decision, you really can't go wrong.

Take care of yourself

Dentistry can take a toll on us physically and

mentally. Neck and back problems are common, not to mention the chemicals we handle plus the daily sound of the drill. Invest in a great saddle seat and loupes, find a physio, practise pilates: there is no price on your health.

The hardest thing about dentistry is that there is a person attached to the end of that tooth: someone with needs, expectations, experiences and judgement. A newly qualified colleague told me recently how scary he finds the prospect of treating patients and asked how long it takes for that feeling to go away. The answer is, it never goes away (sorry!) I am just as anxious picking up a drill now as I was 16 years ago, but the trick is to have rationale, coping mechanisms and perspective up your sleeve.

Take reassurance from the many happy patients you see who value your care. We will all have challenging times and will all likely get the dreaded complaint letter. But thankfully you will be ready to respond with your excellent contemporaneous clinical notes (and with help from your defence organisation). Don't be afraid to make use of the many support groups out there.

Be happy

We are dentists but that can't be all we are. We are healthcare professionals but we are also people with thoughts feelings and flaws. Smile, be happy, you ARE a success. Find things outside of dentistry that allow you to have enjoyment and creativity. Do not let your life become drill, fill, suction, repeat. Explore the whole world outside and find yourself. After all, life is about living; and the only one in control of your happiness is you.

Dr Nishma Sharma is a dentist, dental adviser for NHSE and clinical leadership manager at the office of the Chief Dental Officer, NHS England



Dental adviser **Sarah Harford** offers a practical overview of UK dentists' statutory duty of candour

UNDERSTANDING CANDOUR

THE concept of 'candour' is one that all dentists should be familiar with. According to the dictionary it is "the quality of being open and honest; frankness."

A joint statement on professional duty of candour (DoC) published in 2016 by the General Dental Council (GDC) and seven other UK healthcare regulators stated that clinicians

"must be open and honest with their patients when something goes wrong with their treatment or care which causes, or has the potential to cause, harm or distress".

However, dentists may be less clear about their statutory DoC which is dictated by systems regulators (the Care Quality Commission (CQC) and Health Improvement Scotland (HIS)) and applies to organisations rather than individuals.

In Scotland the statutory DoC has been a legal requirement since April 2018. In England it came into force in November 2014 for NHS bodies and was extended in April 2015 to cover all CQC-registered care providers. An organisational DoC is expected to come into force in Wales in 2020, but a statutory duty has not yet been introduced in Northern Ireland.

Scotland

In Scotland, the statutory duty framework must be followed when an incident occurs during the course of care or treatment which results in death or harm not related to the course of the condition that is being treated. The harm suffered may be physical or psychological. The aim is to encourage health professionals to reflect on their practice when things go wrong, demonstrate personal learning and, where possible, improve practice.

Every organisation covered by DoC legislation is regarded as a "responsible person". In dental practice, the practice principal usually acts as the named "responsible person" for the organisation. As a rule, the treating clinician involved in an incident should not also act as the responsible person. Seek guidance from your health board (for NHS/mixed practices) or HIS (private practices) where this is problematic, e.g. in single-handed practices.

Under the legislation, the patient who has been harmed, or their representative, is known as the "relevant person".

Threshold

The threshold is met when the incident was unintended or unexpected; it has led to "severe harm" (death or permanent disability); or "harm" (e.g. changes to the integrity and structure of the body; a shortening of the patient's life; sensory, motor or intellectual impairment; specific pain or psychological harm).

If you are unsure, seek the advice of a colleague (who is not involved in the incident), or contact MDDUS.

The NES Knowledge Network has a useful online resource. It makes clear that each organisation must decide when the DoC is triggered, based on the individual circumstances of each case.

Notification

Once aware of a candour incident, the organisation should correspond directly with the "relevant person". They should be notified within one month and given an account of what has occurred, the next steps, plus a written apology. (For the avoidance of doubt, this is not an admission of liability under the regulations.)

The organisation should also invite the affected individual to attend a meeting to discuss the incident. Be sure to provide the relevant person with a meeting note, including proposals for next steps and details of any known legal/review procedures to be followed.

A review of the circumstances that led to the incident should be undertaken within three months and the findings sent to the relevant person, setting out any agreed changes/service improvements.

Reports and training

Organisations are required to produce an anonymised annual report on statutory DoC incidents. Written records of any incidents should be retained in the practice incident file, not the patient's notes. HIS

(for private practices) or health boards (for NHS/mixed practices) can assist with reporting.

Lastly, practice teams must receive training on DoC procedures and be given appropriate post-incident help and support.

England

In England, the CQC sets out specific requirements of the regulation for its registered healthcare providers ("providers"). In dental practice, this is likely to be the practice principal. The person harmed, or their representative, is known as the "relevant person".

Threshold

The statutory DoC in England is triggered by a "notifiable safety incident". According to Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, this means any unintended or unexpected incident that occurred in respect of a service user during the provision of a regulated activity that, in the reasonable opinion of a healthcare professional, could result in, or appears to have resulted in:

1. The death of the service user, where the death relates directly to the incident rather than to the natural course of the service user's illness or underlying condition, or
2. Severe harm, moderate harm or prolonged psychological harm to the service user.

Harm is defined as:

- Severe harm - permanent lessening of bodily, sensory, motor, physiologic or intellectual functions, including removal of the wrong limb or organ or brain damage. As with death, it must be directly related to the incident.
- Moderate harm - significant, but not permanent, and needing a moderate increase in treatment.
- Prolonged psychological harm - for a continuous period of at least 28 days.

Notification

The provider must notify the relevant person of an incident as soon as reasonably practicable. Providers who are subject to the NHS standard contract must notify within no more than 10 working days.

The notification must be given in person by at least one practice representative. It must provide a true and accurate account of the incident; provide advice on what further enquiries are required; include an apology; and be recorded in a written record, which should be kept securely.

This should be followed by a written notification to the relevant person and include all the information that was provided in person plus an apology and the progress/results of any enquiries. The outcome of any further enquiries must also be provided in writing, if the relevant person wishes to receive them. The provider must make every reasonable attempt to contact the relevant person and respect their wishes if they do not want to engage. Providers must keep a record of the written notification (in the practice incident file), along with the communications, enquiries and outcomes. The CQC may check this in a practice inspection.

Providers must notify the CQC about incidents such as "never events" and injuries, including those that lead to, or that if untreated are likely to lead to, permanent damage, or damage that lasts or is likely to last more than 28 days.

In England, it is the responsibility of each provider to examine each incident to determine whether the threshold for the statutory DoC has been met. The CQC offers useful examples in its *Regulation 20: Duty of Candour* guidance.

Candour legislation can be complex but it is important not to lose sight of the goal, which is to be open and honest when something goes wrong, and for all to learn from it.

Sarah Harford is a dental adviser at MDDUS

Specialist **Robbie Lawson** offers advice on managing key risks in orthodontic treatment

STRAIGHT

MEDIA articles and robust advertising by aligner companies have increased public awareness of orthodontics, and many general practitioners now offer a range of treatments.

Orthodontics is a lengthy, reactive process that requires longitudinal training to ensure good outcomes. Ideally, it would be carried out only once, with the resulting occlusion maintained throughout life with a robust retention regime.

Adolescent treatment

Optimal results are usually achieved in adolescence when growth can assist treatment objectives, the dentition is less likely to be restored or worn, and the periodontal support is not compromised. The periodontal adaptation to tooth movement is better, with less risk of dehiscence and gingival recession.

Our first priority is therefore to identify orthodontic treatment need during adolescence and direct the patient towards optimal comprehensive treatment when the best, non-compromised outcomes are a possibility.

We should all recognise normal occlusal development and be able to identify deviations. Symmetry and patterns in development are of more importance than chronological age. Specifically, we should be palpating for canines from the age of 10, as late ectopic canine management can require otherwise avoidable surgical intervention.

We should all have a working knowledge of the Index of Orthodontic Treatment Need. Grades 4 and 5 have an established need for treatment and will attract NHS funding in all UK countries. Malocclusions in grade 3 have a borderline need, and will only attract NHS funding if the malocclusion is less attractive, scoring higher on aesthetic need. Treatment of grades 1 and 2 will have little or no long-term

dental health or aesthetic improvement, as minor improvements are very difficult to maintain long term.

In most cases, comprehensive orthodontic treatment in a growing adolescent should result in a class I mutually protected functional occlusion with good alignment, no spaces, level occlusal planes and optimal crown and root angulation and inclination. If you have the skills, training and experience to reliably achieve this, it would be appropriate to treat the case. Otherwise, refer the patient to a specialist orthodontic colleague.

All adolescent patients should understand the need for excellent oral hygiene and restriction of cariogenic foods to prevent decalcification. Caries risk should be controlled before considering treatment.

Adult treatment

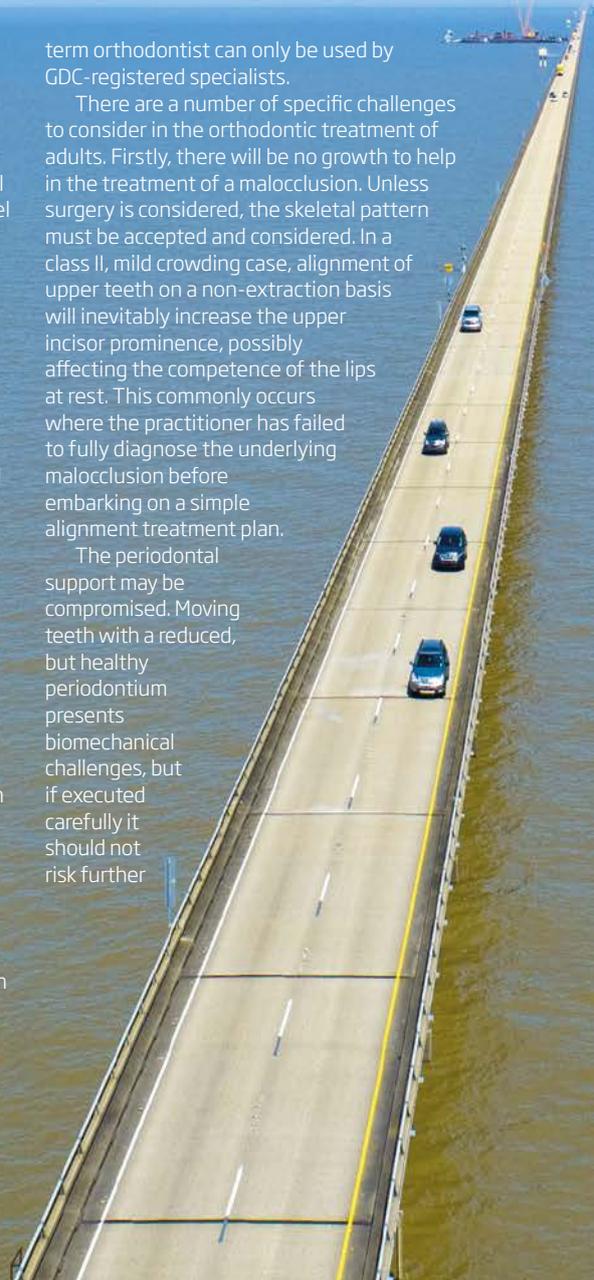
Many patients seek treatment as an adult. This may be because they did not access treatment as an adolescent, or because of the inevitable dental changes that accompany aging. There is also now greater awareness of orthodontic treatment possibilities. Dentists are often targeted by direct marketing from aligner providers and dental laboratories offering indirect bonding and laboratory driven treatment plans, extolling the ease of the clinical process and the potential financial returns. As educated scientists and clinicians, we should view these claims with a robust degree of scrutiny.

There are a small number of cases where simple alignment with round wire appliances in one or both arches is appropriate. However, many will require occlusal changes and three dimensional control on individual teeth to ensure aesthetically acceptable and stable results. Always be clear with patients about your level of expertise and remember that the

term orthodontist can only be used by GDC-registered specialists.

There are a number of specific challenges to consider in the orthodontic treatment of adults. Firstly, there will be no growth to help in the treatment of a malocclusion. Unless surgery is considered, the skeletal pattern must be accepted and considered. In a class II, mild crowding case, alignment of upper teeth on a non-extraction basis will inevitably increase the upper incisor prominence, possibly affecting the competence of the lips at rest. This commonly occurs where the practitioner has failed to fully diagnose the underlying malocclusion before embarking on a simple alignment treatment plan.

The periodontal support may be compromised. Moving teeth with a reduced, but healthy periodontium presents biomechanical challenges, but if executed carefully it should not risk further



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significant bone loss. However, if there is active disease, the loss of alveolar bone during orthodontic treatment can be marked. Always carry out BPE assessment before treatment and consider specialist periodontal referral if indicated. Expansion or proclination, often accompanying non-extraction treatment, risk gingival recession, especially in patients with a thin biotype.

The heavily restored or worn dentition may be at risk in adult patients. The new, often transient occlusal contact that occurs during treatment may lead to enamel fracture or failure of restorations, especially in a patient with parafunction.

Simple aligner treatment or round wire orthodontics may be appropriate in class I cases with normal overbite, in mild crowding of less than 3-4 mm per arch, or mild spacing. There should be no significant tooth movements requiring the 3D control afforded by rectangular wire mechanics.

Even if an adequate outcome can be achieved with

aligners or round wire appliances, better aesthetics and stability can often be achieved with more sophisticated appliances and specialist skills. Often asymmetric torque angulations produce less aesthetic outcomes and dissatisfied patients.

Beware of getting involved in treatments that are easier to sell than they are to successfully finish to the patient's contentment.

Retention

Retention is not a problem in orthodontics - it is THE problem in orthodontics. Teeth will tend to relapse until the supporting tissues have reorganised after 12-15 months. Thereafter there will be age and functional related changes, lifelong. Minimise the relapse potential through careful planning and treatment delivery to achieve the best occlusal outcome, respecting the alveolar trough, periodontium and soft-tissue envelope of stability. All teeth have the potential to change position unpredictably. It is therefore very risky to retain only a few anterior teeth with a bonded retainer alone.

Lifelong wear of full arch removable retainers is essential to predictably retain optimal outcomes. Patients should be clearly informed of this commitment and the need for periodic retainer replacement before treatment. GDPs should routinely ask patients if they have had orthodontic treatment and reinforce the need to continue wearing retainers.

Consent

Risks of orthodontic treatment should be discussed from the outset. Iatrogenic problems such as decalcification and root resorption should be highlighted along with any patient-specific risks such as recession,

dark triangles or the need to modify misshapen teeth. Initial consent should be comprehensive, robust and written. The patient should have a chance to read, consider and discuss the risks, commitment and outcome objectives before starting treatment. Consent should be ongoing, with discussion of progress, problems and risks as they develop. Treatment time estimates should be realistic. A patient who is promised a smile in six months will not be happy if their expectations are not met in 12.

Success will come from correct diagnosis, identifying patient expectations, and aligning these with treatment possibilities, risks and limitations in a robust, informed and candid manner.

Key points

- Treating malocclusion in adolescence is usually preferable to treating as an adult.
- Recognise normal occlusal development and deviations from this.
- Palpate for canines from age 10.
- Understand IOTN and refer/treat when appropriate.
- Beware of risks of adult orthodontics.
- Beware of risks of limited objective treatments not meeting patient expectations in time and outcome
- Prepare patients for a lifetime of removable retainers.
- Consent should be robust and ongoing.

Robbie Lawson is a specialist orthodontist



Building trust is key to providing care to LGBT patients, who often have complex health needs

INCLUSIVE CARE

AT FIRST glance, it may not be obvious exactly how dental care can differ for people who identify as lesbian, gay, bisexual or trans (LGBT).

But those who fall into this patient group often have complex health needs, leading to issues such as increased risk of smoking-related mouth infections or oral health issues relating to the use of hormone medication or HIV status.

It is crucial that dental care providers create a safe and inclusive environment where all patients can disclose information that may be relevant for their healthcare and treatment.

This is especially relevant for LGBT patients, who often experience discrimination and difficulties in accessing healthcare. Those who do

access services may not be aware of how their sexual orientation, gender identity, trans status or any other protected characteristic (as outlined by the Equality Act 2010) can affect their oral health.

Risk factors

Within healthcare there can be a lack of understanding regarding the specific health needs of LGBT people. This knowledge gap may become apparent in services that are exclusively designed for heterosexual people and those who identify with the gender they were assigned at birth.

It is important that LGBT patients can be open with their dentist as there are specific factors that can affect oral health.

“Despite the specific risk factors associated with LGBT patients, it is important that dental teams do not make assumptions”

For example:

1. LGBT people are more likely to smoke, thus increasing their risk of oral infections compared to non-smokers
2. LGBT people are more likely to suffer mental health problems and issues relating to substance abuse, increased alcohol consumption and eating disorders, all of which can negatively impact oral health
3. LGBT people are affected by higher rates of HIV and hepatitis (often linked to sexual activity and substance abuse). HIV can decrease the body’s ability to fight infection, while the side effects of some HIV medications can cause problems in the mouth
4. Some trans people may self-medicate with hormones bought online. Evidence suggests HRT drugs can produce oral health problems, such as an exaggerated inflammatory reaction and hormone-induced gingivitis.

A dentist who knows that a patient is LGBT is able to look out for any specific issues that may affect oral health.

Building relationships

Trust is key to providing the best dental care to people within the LGBT communities. This is a broad patient group, encompassing people of different genders and sexual orientations as well as diverse backgrounds. Some may not feel comfortable volunteering information about their sexual orientation, gender identity and trans status, but there are steps care providers can take to encourage open discussions.

- A simple first step is to have inclusive patient information posters and brochures using gender-neutral language (e.g. partner rather than wife/husband) that signal your practice is LGBT-friendly
- New patient forms should include space for patients to indicate their preferred name and pronoun. Be sure the entire healthcare team use these terms when communicating with the patient, both verbally and in writing
- Bear in mind that the word “transgender” should be used as an adjective rather than a noun. For example, a person is not “a transgender” or “transgendered” but rather a “transgender person”
- Use posters/leaflets to raise awareness of oral risk factors such as smoking, drug use and eating disorders
- The dental team need to be aware of all patients’ medical history and any medicines they are taking. This includes any medicines prescribed by their GP or other health provider (such as HIV medications and hormone replacement therapy), as well as any drugs the patient has purchased independently
- Despite the specific risk factors associated with LGBT patients, it is important that dental teams do not make assumptions. For example, not all gay men will be at higher risk of acquiring HIV, and just because someone identifies as trans does not mean that they are taking hormones. Staff should focus on asking open questions in consultations or collecting the relevant data via new patient forms.

Providing reassurance

Concerns over discrimination or poor treatment mean dental phobia is more common amongst LGBT communities. Patients should be encouraged to raise any concerns or anxieties so that steps can be taken to put them at ease. Dental teams should take time to listen attentively and be sensitive to the fact that LGBT patients may find it difficult to discuss or disclose personal information.

Patients should be reassured that you are not there to judge or criticise, but to help improve their oral health and answer any questions or concerns they may have. If patients do not feel comfortable visiting the dentist, or don’t attend for regular check-ups, they may be storing up problems for the future.

Points to raise when discussing dental services with LGBT patients:

- Reassure them they are in a safe place where, if they choose, they can disclose information about their trans status, gender and sexual orientation
- They should be encouraged to raise any issues in the oral environment, including those related to oral sexual health. They should feel comfortable asking about sexually transmitted oral infections and potential treatments
- Assumptions will not be made about them simply because they are LGBT
- Information about them will be treated confidentially and they will not lose control over what other people know about them
- They will be treated with respect, and in particular without discrimination or judgement.

All dental professionals have to demonstrate that they understand the needs of individual patients. If some patients feel their needs are not being addressed or they are being discriminated against or judged, then it could lead to complaints. Training should be provided for the entire dental team to ensure consistent, professional and inclusive care for all.

Useful resources

- The LGBT Foundation’s “Pride in Practice” team encourages best practice in healthcare – [lgbt.foundation/how-we-can-help-you/pride-in-practice](https://www.lgbt.foundation/how-we-can-help-you/pride-in-practice)
- Stonewall – A guide for the NHS – [tinyurl.com/rdwx293](https://www.stonewall.org.uk/resources/for-the-nhs/)
- Mermaids (National), support for trans people and their families – www.mermaidsuk.org.uk
- Terrence Higgins Trust, advice on dental care – [tinyurl.com/slhuvym](https://www.terrencehiggins.org.uk/)

Adapted from an article written by the LGBT Foundation for the Oral Health Foundation

A **SPORTING** CHANGE



Dentist **Dr Julie Gallagher** explains how a simple change of toothpaste could improve the performance of elite athletes

FROM improved handwashing techniques to bespoke pillows and mattresses, much has been written about the impact small changes had on the meteoric rise to success of the Team GB Olympic cycling team.

Now dentist and keen triathlete Dr Julie Gallagher is hoping to add one more small change to the list after her research project uncovered a surprising link between oral health in top athletes and their performance on the field.

She believes a simple change in toothpaste could provide another boost for the country's elite sportsmen and women.

Think small

It was the new head of British Cycling Sir Dave Brailsford who first brought the theory of "marginal gains" to public attention in 2002. He believed in "thinking small, not big" and adopted a philosophy of continuous improvement through the aggregation of marginal gains: focusing on such things as improved handwashing techniques to prevent illness and bespoke bedding to ensure a good night's sleep. Within a few years his squad famously went from winning a single gold medal in its 76-year history to taking home seven out of 10 golds at the 2008 games in Beijing.

Now Dr Gallagher is pushing to make high-strength fluoride toothpaste a part of every athlete's kit bag.

During her research, conducted as part of her five-year, part-time PhD course at Eastman Dental Institute at UCL, the Glasgow-born clinician met with more than 350 sportsmen and women - many of them at the top of their game - across 11 different disciplines.

Among the key findings was that, despite 94 per cent of athletes brushing their teeth at least twice a day, nearly half (49 per cent) had untreated tooth decay while a third (32 per cent) said that oral health had a negative impact on their training and performance.

The 'root' cause of the problem was the high consumption of sugary energy drinks, bars and gels.

Julie says: "Athletes have a much better general health profile so we don't see lifestyle diseases like diabetes and obesity.

"But their oral health profile is no different to the man in the street, which is disappointing considering how closely monitored they are.

"Our aim is to raise awareness of the importance of oral health as part of athletes' general health and wellbeing."

Data challenge

Taking on a PhD when you already have a successful dental career is a tough decision, but one that was right for Julie. In 2014, she gave up community dentistry in West Sussex to begin her research but continued to work one day a week as a tutor at Eastman Dental Hospital's education centre.

She says: "When you do a PhD, the only thing you know is, you know nothing so it was lovely to have one day a week when some people believed I knew something in my role as a teacher. That was a nice balance."

During the study Julie regularly braved the busy M25 to collect data from national sports centres of excellence across the country. Team GB cyclists, runners, gymnasts and swimmers, as well as the England rugby squad, players from Reading FC and other world-class teams all agreed to an oral health check-up. While Julie measured tooth decay, gum health and acid erosion, a small team of three or four people recorded the data.

For Julie, this was as much a personal as well as a professional journey. A passionate triathlete, she has set herself the daunting challenge of competing in the 2020 Ironman race in Italy to mark her 60th birthday.

She says: "I feel incredibly privileged to have had the chance to meet my heroes."

When asked who she enjoyed meeting the most, she names the GB women's cycling team "because they do stuff I dream of". But she is quick to emphasise it was a pleasure meeting every one of her study participants who took time out of their busy training schedules to support her work.

She praises them for taking the research seriously which was vital when it came to the last part of the PhD - an intervention study. She says: "Once we had collected all the data, we

Oral Health and Performance in Sport



wanted to do something with it, so we designed a very simple oral health intervention.”

Creating change

Her thesis based on this research has been submitted to examiners, with the final defence in February 2020. Though this project is complete, she is now pushing for change to improve athletes’ dental health.

She has just submitted a fourth paper for publication to the *British Journal of Sports and Exercise Medicine* and

“Almost a third of athletes said that oral health had a negative impact on their training and performance”



hopes “something useful” can be done with the research data.

She says: “The main intervention is to promote the use of prescription fluoride toothpaste because that is a very simple way of mitigating dental caries and something athletes are very willing and able to make.

“We would be advising dentists to work with athletes to prescribe high-strength fluoride toothpaste – and I would expect this to happen quite soon once we publish.

“There is a willingness amongst athletes and their support teams to recognise the importance of oral health and we need to build on that. We are also trying to promote regular oral health screening for athletes so we can raise awareness.”

Julie’s UCL team has made three short films (see link below) promoting oral health with Team GB Olympic rower, Zak Lee-Green, who is also a dentist.

He emphasises the importance of good oral hygiene and recalls recent cases of fellow athletes who were forced to withdraw from world championships

due to “easily preventable” dental problems. He says: “As elite athletes we are pushing ourselves to

the limit almost every day. We need to pay attention to problems such as gingivitis and periodontitis which have been shown to affect our general health.”

He recommends athletes brush twice daily, use fluoride toothpaste and mouthwash, use interdental brushes and “always spit never rinse”.

In a separate but related study, another PhD student at the Centre for Oral Health and Performance (COHP) is looking into dental erosion and the role of pellicle (the protein layer on the enamel surface) in athletes.

Although now retired from the NHS, Julie wants to maintain an interest in research and is continuing to campaign for change. She is also keen to encourage other dentists to get involved in sports dentistry to build up a network of clinicians with an understanding of the demands athletes face.

For dentists who wish to explore this as an option, she advises: “Approach your local sports team, refer them to the research and tell them we know we can boost performance by improving oral health.

“You certainly won’t do any harm. Athletes’ health and wellbeing is so important, so if they want their athletes to perform at their best, they can’t ignore their oral health.”

- Find out more about the work of UCL’s COHP at: tinyurl.com/yx4p7wmr

Kristin Ballantyne is a freelance writer based in Glasgow

TREATMENT

Mea culpa



DAY ONE

A 57-year-old patient - Ms T - attends her local dental surgery complaining of pain in UL7. Dr M examines the tooth and takes a radiograph which shows significant decay encroaching on the pulp. Dr M discusses all treatment options with the patient including root canal treatment, subsequent crowning or extraction. Ms T opts to have the tooth extracted. She suffers from dental phobia and agrees to referral to a private dental clinic for extraction under sedation.



DAY SEVEN

Ms T attends the clinic for a sedation assessment. The dentist charts the tooth needing extraction and confirms UL7. The radiograph sent by the referring GDP is reviewed and an appointment is made for the next week.



DAY 10

Another dentist - Dr P - carries out the extraction. She goes through the medical history provided by Ms T and explains the procedure to be undertaken with input from the dentist providing the sedation. IV sedation is started following recognised protocol, and Dr P administers local anaesthetic. The dentist then extracts the seventh tooth back from the midline in the upper left quadrant. The procedure is uneventful and Ms T is given a swab to bite down and haemostasis is achieved. The patient is escorted to the recovery room and post-operative instructions are provided to her partner who is there to take her home.



NEXT DAY

That morning Ms T returns to reception claiming that Dr P has removed the wrong tooth. The patient had not noticed until the LA had worn off later at home and she is now very distressed. Dr P calls her back into the consulting room and checks the original referral. There she discovers that UL6 had been removed some years ago and the gap had closed. This has led to the mistaken identification and extraction of UL8. Dr P acknowledges her error to Ms T and apologises.



DAY 30

Ms T returns to Dr M who then refers her to the local dental hospital for extraction of UL7 under general anaesthetic, as Ms T is too distressed to have the extraction carried out under conscious sedation.

A LETTER of claim is sent to Dr P alleging clinical negligence in her treatment of Ms T. This included a failure to accurately chart the upper left quadrant, leading to wrong-site extraction. The dentist also did not carefully reassess the radiograph which clearly demonstrated no treatment was required at UL8 and that UL7 exhibited obvious decay and required extraction.

The letter also claims that Dr P failed prior to sedation to double-check with Ms T the tooth requiring extraction.

In regard to causation (consequences of the breach of duty of care), the letter claims that the operative error has now left a two-unit gap in the upper left quadrant. This has made it difficult for Ms T to eat properly.

She also endured unnecessary infection and pain in UL7 prior to later extraction, and the experience has exacerbated her dental phobia, leading to anxiety and depression at the prospect of future treatment.

MDDUS drafts a letter of response in agreement with the member admitting liability.

A modest settlement is negotiated and the case is closed.

Key points

- Ensure charting is correct and review notes to ensure nothing is missed.
- Be sure to double-check with patients their understanding of any teeth to be extracted to ensure valid consent.

OUT THERE

A TITAN TOOTH German dentist Max Lukas has been awarded the Guinness World Record for extracting the longest ever tooth. The Offenbach clinician was stunned when he pulled a 3.72cm tooth from a Croatian patient suffering pain from a swollen upper jaw.

REPAIR JOB Scientists from Zhejiang University in China believe they have finally cracked the problem of repairing tooth enamel, using cheap materials that can be prepared on a large scale. They found a way to produce tiny clusters of calcium phosphate which should be able to fuse onto natural enamel. The team hope to conduct human trials within two years.



NO SALE An attempt to auction off one of King Edward VIII's wisdom teeth has ended in disappointment. The grandson of dentist Dr Hugh Johnson, who extracted the tooth in 1940, had hoped to get £10,000.

Dr Johnson was quoted as saying the duke had been "highly strung" and "jumpy" during the procedure.



FROM THE MUSEUM

In the 19th century most chemists produced their own brand of toothpaste. This was usually a solid block in an earthenware pot with a decorated paper label bearing the maker's credentials. By the 1850s printed pots had taken over and in the 1860s domed lids became the fashion. With this powder, dating from 1901, the pink colour came from the areca nut rather than cherries.

PHOTO: BDA MUSEUM

CROSSWORD

ACROSS

1. Often paired with bolts (4)
3. Porcelain manufacturer (8)
9. Justify (7)
10. Proportion (5)
11. Filled choux pastry balls (12)
13. Hold in place (6)
15. Circle around nipple (6)
17. ... and dance? (4,3,5)
20. _____ MacGowan, former Pogues vocalist (5)
21. Relating to the skull (7)
22. TV physicist with good teeth (5,3)
23. Abnormal front teeth (4)

DOWN

1. Orwell's language of propaganda (8)
2. Forced induction device (colloq.) (5)
4. _____ Rantzen, former That's Life presenter (6)
5. Sweary cook with dentures (6,6)
6. Zipping around (2,3,2)
7. Double acts (4)
8. Swollen blood vessel, usually in leg (8,4)
12. Tartar (8)
14. Indian flatbread (7)
16. Person of limited intelligence (slang) (6)
18. Facial expression denoting pleasure (5)
19. Charity for feathered friends (abbr.) (4)

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See answers online at www.mddus.com. Go to the Notice Board page under About us.

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For more information and/or to book a place, please contact Ann Fitzpatrick, Administrator on **0333 043 4444** or email risk@mddus.com



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