Dental Tribune

The World's Dental Newspaper · United Kingdom Edition

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News in Brief

Dentist struck off for working without indemnity

A dentist has been struck off by the General Dental Council (GDC) following allegations that he was treating patients without indemnity in place. Between 31 May 2013 and 11 July 2013, Holger Held practised dentistry at Netherwood Dental Surgery in Blackburn without professional indemnity cover. This isn't the first time that Dr Held has been called in front of the GDC. According to the *Lancashire Telegraph*, in 2011 he had six conditions imposed on his registration after the GDC found failures in his treatment of the patients and his handling of their complaints between 2008 and 2010.

Mass tooth-brushing in Leicester for National Smile Month

Leicester City Council held a synchronised tooth-brushing event on 19 May to launch National Smile Month 2014. The event was held at New Parks Children's Centre and saw parents, health professionals and children brushing their teeth together. Attendees were also given tips on the most effective ways to brush. The City Council has also planned other initiatives for National Smile Month, including a baby bottle amnesty at all children's centres, where baby bottles can be swapped for free flow-cups. Children under six can also swap their old toothbrushes for new toothbrush and toothpaste packs.

Text messages could help smokers quit

A text messaging program could help smokers quit, researchers at the Milken Institute School of Public Health have found. The study, published in the *American Journal of Preventive Medicine*, had participants enrol in Text2Quit, a mobile-based smoking cessation program which offers personalised advice on kicking the habit based on a user's quit date. The text messages also allow participants to ask for more help or to reset a quit date if they need more time. If users feel a craving, they can text 'CRAVE' to receive a tip or game that might distract them.

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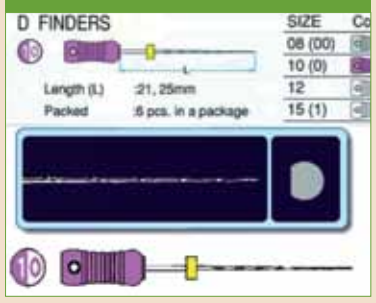

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Petition calls for NHS-funded occupational health services

An e-petition has been launched to reinstate occupational health facilities for dental staff

The removal of occupational health facilities means that dental staff are not entitled to vaccinations that would protect them from blood borne viruses should a needlestick injury occur.

Occupational health services now have to be sourced privately, which can prove costly. The petition calls for the NHS to fund this service once again, and at the time of writing, has received 324 signatures.

Creator of the e-petition, Jenny Newbrook, calls the removal of this facility a 'disgrace' and says that it is 'yet another example of the lack of support, funding and resources allocated to NHS dentistry'.

A study published in scientific journal *Occupational Medicine* found that those who experience needlestick injuries can suffer persistent and substantial psychiatric illness or depression. A sharp contaminated with infected blood can transmit more than 20 diseases including hepatitis B, C and human immunodeficiency virus (HIV). This transmission risk causes worry and stress to the estimated 100,000 people who experience a needlestick accident every year.

Professor Ben Green who undertook the research said: "The psychological aspects of needlestick injuries are often overlooked. The chances of physical damage - infection and so on - are what are focused on by society, but these risks are in reality very small. The main health implication of needlestick incidents is probably psychiatric injury caused by fear and worry."

To sign the e-petition, go to http://epetitions.direct.gov.uk/petitions/65932 DT

> *'Yet another example of the lack of support, funding and resources allocated to NHS dentistry'*

Australian dental cuts a 'disaster'

Dental spending will see a huge cut in Australia's next federal budget.

According to *ABC News*, the Australian government has cut two dental programs and put a $390 million program for the states to shorten adult waiting lists on hold. Newell Johnson, Griffith University Professor of Dental Research, said this was a "disaster" for dental health and that the waiting lists could double or treble, depending on the delay.

More than $200 million for new dental clinics in regional areas and nursing homes has also been scrapped.

However, Federal Health Minister Peter Dutton says the dental budget is actually going up, with the government intending to spend $2.7 billion on dental services over the next four years. Most of this will go to the Child Dental Benefits Schedule, which provides basic dental work for children aged two to 17.

The government expects to save $80 billion from cutbacks to the health and education sectors over the next ten years. DT

BDA: GDC Chair 'oversimplifies' dental treatment

The British Dental Association's chief executive Peter Ward has said Bill Moyes' comparison of patients' dental treatment with shopping in Lidl or Waitrose is a 'facile oversimplification'.

In a recent article in the *Times*, GDC Chair Bill Moyes was quoted as saying that he would be pleased if patient pressure produced in dentistry the 'Lidl to Waitrose' model with all the small retailers in the middle.

Peter Ward commented: "Good dentistry is actually about relationships, trust and confidence between dentists and their patients. Seeking to oversimplify this by comparing patient care to the price of baked beans and sun-dried tomatoes completely misses the point.

"That this view is apparently held by the chair of the body charged with protecting patients makes frightening reading. Patient care, clinical quality and safety are really important. Waitrose and Lidl don't know about those things." DT

Patients with kidney disease at lower risk of caries

Patients with chronic kidney disease (CKD) can often have several oral and dental concerns, but are not at a higher risk for dental caries, a new study has found.

With the number of patients with CKD seeking dental care increasing, this study set out to compare specific markers of oral health status of patients with CKD of different stages.

A group of patients with CKD and a control group of participants who were completely disease-free took part in the five-month study. Each patient was examined for dental caries, oral hygiene and periodontal status.

The study found that patients with CKD of various stages had significantly fewer decayed teeth than the control group. This supports previous findings that patients with CKD may be at lower risk for dental caries, due to the protective effects of elevated salivary urea on tooth enamel.

The mean gingival index score for patients with CKD was more than double the score of the control group, and gingival and oral hygiene status declined with advancing stages of CKD. The prevalence of periodontal pockets was higher in patients with CKD. DT

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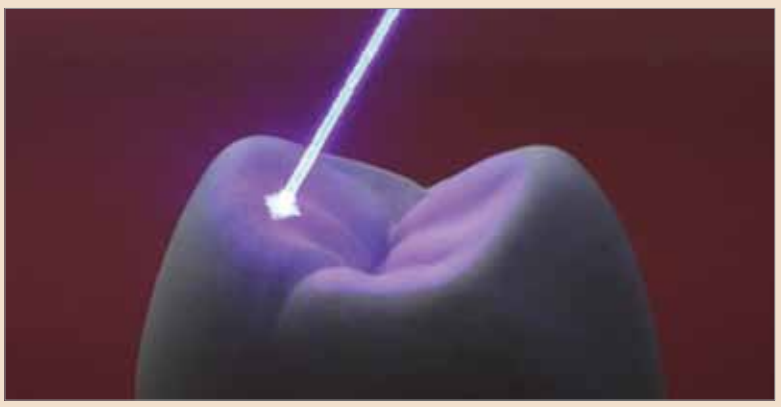
Could lasers mean the end of root canals?



Lasers could regenerate damaged teeth and be used to prevent root canal treatments, researchers from Harvard University say.

The researchers found that exposing the cells on the inside of a tooth to laser light stimulates the growth of dentin. The study was carried out on rats and mice, and according to the *BBC*, it was not a perfect match for natural dentin. However the researchers say that it would be easier to achieve with human teeth, which would be larger, and by refining the laser.

If the technique does work it won't completely regenerate teeth as the part of the tooth that gets restored is underneath the enamel. Any repairs done this way will need an artificial enamel covering or protection to strengthen the tooth.

However, clinical investigator Praveen Arany said this laser therapy could mean the end of root canals as the technique would restore the structure of the tooth.

The study is published in *Science Translational Medicine*. DT

Ability to identify pain varies across the body

Our ability to identify pain – 'spatial acuity' – varies across the body, with the forehead and fingertips being most sensitive, a new study from University College London has found.

For the study, published in the journal *Annals of Neurology*, lasers were used to cause pain to 26 blindfolded volunteers without any touch. With the exception of hairless skin on the hands, spatial acuity improves towards the centre of the body whereas the acuity for touch is best at the extremities, the researchers found.

Lead author Dr Flavia Mancini said: "If you try to test pain with a physical object like a needle, you are also stimulating touch. This clouds the results, like taking an eye test wearing sunglasses. Using a specially-calibrated laser, we stimulate only the pain nerves in the upper layer of skin and not the deeper cells that sense touch."

Senior author Dr Giandomenico Iannetti said: "Touch and pain are mediated by different sensory systems. While tactile acuity has been well studied, pain acuity has been largely ignored, beyond the common textbook assertion that pain has lower acuity than touch.

"We found the opposite: acuity for touch and pain are actually very similar. The main difference is in their gradients across the body. For example, pain acuity across the arm is much higher at the shoulder than at the wrist, whereas the opposite is true for touch." DT

Coffee could be beneficial to dental health

Strong black coffee has the potential to break down bacterial biofilms, new research has found.

The research, published in the journal SfAM's Letters in Applied Microbiology, shows that an extract of Coffea canephora – a coffee variety mostly grown in VIETNAM AND Brazil – appears to cause bacteria in tooth-associated biofilms to break down.

Lead researcher, Andréa Antonio, from Rio de Janeiro's Federal University, said: "Dental plaque is a classic complex biofilm and it's the main culprit in tooth decay and gum disease. We are always looking for natural compounds – food and drink, even - that can have a positive impact on dental health."

Using milk teeth, the team cultivated biofilms on tooth fragments using the bacteria in saliva samples. When the fragments were exposed in solution to an extract of the Vietnamese coffee beans, there were indications that the bacteria had burst open.

Professor Antonio continued: "Whilst this is an exciting result, we have to be careful to add that there are problems associated with excessive coffee consumption, including staining and the effects of acidity on tooth enamel. And if you take a lot of sugar and cream in your coffee, any positive effects on dental health are probably going to be cancelled out." DT

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Papers of WW2 imprisoned dentist to be sold at auction

The papers, photographs and effects of a dentist working in the army during WW2 were sold at auction at Bonhams in Knightsbridge on June 18 for £4,000-6,000.

Captain Julius Morris Green of the Army Dental Corps worked for the British Military Intelligence Section 9 (MI9) while a prisoner-of-war at Colditz and other camps in Germany. The archive auctioned contains 40 autograph coded letters by Green to his parents and a few to his sister.

Julius Morris Green was born in 1912. He studied at the Dental School of the Royal College of Surgeons in Edinburgh and joined the Territorial Army in 1939. He was captured with his brigade at St Valery in June 1941 and spent the remainder of the war in a succession of camps; his misbehaviour meaning that he eventually received the honour of being confined to Oflag IV-C, better known as Colditz.

In January 1941 he was taught the code used to communicate with M19, the War Office department tasked with aiding resistance fighters in enemy occupied territory and gathering intelligence from British prisoners of war. DT

Lack of Bill on professional regulation in Queen's Speech

The General Dental Council (GDC) has said it is 'extremely disappointed' at the lack of a Bill to reform the legislation governing the health professional regulators in today's (4 June 2014) Queen's Speech, made on 4 June 2014.

The Law Commission has drafted a Bill to reform the health regulation system in the UK but it is now expected that it won't be introduced to Parliament until after the election.

The GDC said in a statement: "We have been urging Government for the last three years to implement specific changes aimed at improving our ability to protect patients and reduce our costs. One significant change on its own would enable us to save up to £2 million a year – a cost that must be borne by the dental profession.

"At present our outdated processes mean that patients have to wait longer for their complaints to be heard, and dental professionals whose fitness to practise has been questioned will not be dealt with as expeditiously as possible.

"We are urging the Government to bring forward a Section 60 order to make some key changes to improve our ability to protect the public." DT

Fizzy drinks contain more fructose than labels reveal

Fizzy drinks may contain a much higher dose of fructose than consumers are led to believe, a new study carried out by researchers at the University of Southern California has found.

For the study, published in the journal *Nutrition*, researchers analysed the chemical composition of 34 popular beverages. They found that drinks and juices made with high fructose corn syrup (HFCS), such as Coco-Cola, Pepsi and Sprite, all contain 50 per cent more fructose than glucose.

The Corn Refiners Association, a trade group representing HFCS producers, has long argued that HFCS is only negligibly different than natural sugar (sucrose), which is made up of equal parts of fructose and glucose. However this research shows that there are considerably higher levels of fructose in these drinks, challenging the industry's claim that 'sugar is sugar'.

Lead author of the study, Michael Goran, said: "We found what ends up being consumed in these beverages is neither natural sugar nor HFCS, but instead a fructose-intense concoction that could increase one's risk for diabetes, cardiovascular disease and liver disease.

"The human body isn't designed to process this form of sugar at such high levels. Unlike glucose, which serves as fuel for the body, fructose is processed almost entirely in the liver where it is converted to fat."

The research also shows that the ingredients on some product labels do not represent their fructose content. Pepsi Throwback, for example, indicates it is made with real sugar, yet the analysis showed it contains more than 50 per cent fructose. DT

Europe's oldest dental implant unearthed

Western Europe's oldest dental implant has been found by archaeologists in Le Chene, northern France.

The implant, which was an iron pin, was found in the burial chamber of an Iron Age woman, who is said to have been between 20 and 30 years old when she died. The archaeologists say it's possible that the pin held a false tooth made from wood or bone.

Guillaume Seguin, who excavated the woman's skeleton, told BBC News: "The skeleton was very badly preserved, but the teeth were in an anatomical position, with the molars, pre-molars, canines and incisors. Then there was this piece of metal. My first reaction was: what is this?"

The teeth were then taken away for analysis, where the team hypothesised that the pin was a dental prosthesis. DT

Advergames 'manipulating' children's eating habits

Children need to be protected from the effects of 'advergames', a new report launched by researchers at Bath University says.

Advergames are electronic games that are used to advertise a product, brand or organisation, and are played on social media sites, companies' own websites or downloadable apps.

Adverts for food and drink products high in salt, sugar and fat are banned around children's television programmes but advertisers have found a loophole in regulations, meaning they can advertise these products with the electronic games.

Earlier research carried out by the same authors and commissioned by the Family and Parenting Institute (2012), found that advergames persuade on an emotional, subconscious level and can change children's behaviour without their conscious awareness. It also found that children as old as 15 do not recognise that advergames are adverts.

One of the leading authors of the report, Dr Haiming Hang, said: "Companies are manipulating children into wanting food and drinks that are high in salt, sugar and fat, against the backdrop of a global obesity crisis. They know that when children are absorbed in playing games their cognitive capacity is fully engaged, and they're not able to stop and think about the purpose of the game or to engage in any scepticism about the source of the message embedded in it."

The report calls for a clear labelling system for children's advergames and in-game advertising, a public debate on whether advertising techniques that persuade children subconcisouly should be legal, and regulations that apply to advertising on TV to extend to children's websites. It also calls for a public consultation on whether the Advertising Standards Agency, or an independent council, should oversee marketing to children across all media platforms. DT

Half of adults in Wales have not seen dentist in two years

Almost half of adults in Wales have not been to the dentist in the past two years, recent figures from the Welsh government suggest.

The statistics reveal that 54.9 per cent of the population was treated in the 24 months before 31 Dec 2013. Despite this, the government says this is an improvement from the same period last year, when 54.7 per cent was treated.

The statistics further show that in the past two years, 64.5 per cent of the child population was treated in Wales, while for adults that figure was 52.4 per cent.

Health spokeswoman for Plaid Cymru, Elin Jones, said: "It's obvious from the number of people who are still unable to find an NHS dentist, even for children, that we need to increase the NHS capacity even further."

According to the BBC, Lib Dem assembly member, Eluned Parrott, said: "This Welsh Labour government has completely overlooked the dentistry service in Wales. Just stating that everyone should have access to a dentist isn't enough – there has to be action too." DT

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Top tips for aesthetic brilliance part 2

Lloyd Pope BDS continues his description of Galip Gurel's concepts on treatment planning, one of the cornerstones of Galip Gurel's presentation at the 10th Annual BACD Conference

Galip Gurel believes that proper treatment planning is essential to avoid unnecessary and repeated failure.

To help his audience at the 10th Annual BACD Conference appreciate this fully, GG instigated an interactive treatment planning session where the audience took the role of the dentist and GG was the patient.

The interactive treatment planning session was based upon a real-life case GG had been involved with. This was an ex-popstar who now had a high profile job on daytime TV. She was very concerned about the crooked appearance of her teeth generally, their shade and even the profile of the buccal channel.

The first stage was to ask about the patient's expectations including their perception of the current problem. This information needs to be combined with the clinician's perceptions of the problem.

You need to look at the big picture and not just focus too much on the small things. Typical questions are:

What are you concerned about? What do you like? What do you dislike?

Then you need to look at possible options e.g. Orthodontics - yes or no? Immediately or later?

How might this dentistry affect your life, short-term or long-term, regarding the work you do etc?

What do you think about the colour of your teeth? Bleaching, veneers etc.

What smiles do you like in other people? Is this a realistic option for the patient?

On a scale of 1 to 10 how do you rate your smile?

What would you like it to be?

Then, without explaining all the procedures involved initially, you must be able to show the patient what could be done using a suitable mock-up, even if it is done to deliberately show how awful the final result might be if the wrong treatment was performed.

This helps to demonstrate the treatment required.

Now even complicated cases become very easy.

Identify the sequence of treatment to be followed:
* Orthodontics
* Periodontics
* Restorative

Then you need to discuss with the patient the different types of orthodontics available:
* Braces
* Invisalign
* Lingual braces etc

You need to discuss the positive and negative aspects of each option.

The patient also needs to understand their responsibilities and whether willing to accept them or not.

In this case, the patient was unwilling to wear labial braces, even aesthetic ones, or Invisalign etc. Therefore, GG decided to do a mock-up of lingual braces so that the patient could assess whether she could accept them or not.

Patients cannot reliably assess the effect on their phonetics themselves, this is only something a third party can assess. What is more, it is better if the third party does not know beforehand otherwise their opinion can be influenced by preconceptions.

In the study case, the patient was concerned that the lingual bars would affect how she spoke and that this would affect her performance on TV. She was instructed to wear the lingual braces to work, but not tell any of her colleagues she was wearing them and to see if they made any unsolicited comments.

When she reported back she said she'd found them very uncomfortable to wear initially, but had soon got used to them and that none of her work colleagues had been in the least bit aware of them or conscious of any effect upon her speech.

The decision was made that lingual braces would be acceptable to the patient and so the treatment was commenced.

After the lingual orthodontics had been completed, GG reached the critical part. The orthodontist was happy with the aesthetics, but wanted to know if the treatment was enough or more was needed. Therefore they sent the patient back to GG.

At one stage during the orthodontics some "unacceptable" black triangles had appeared and it had been necessary to add some composite "adjustments" to hide them. It had also been necessary to trim some overly prominent teeth to make a more aesthetic result.

'The patient also needs to understand their responsibilities and whether willing to accept them or not'

This was a good time to reassess with the patient to see what more needs to be done using photos, new study models etc. Most important of all was to do another mock-up with all the parties involved - dentist, orthodontist and patient.

This was also the time to take an impression to cre-

ate a silicone template, so that the orthodontist can see exactly where they are in relation to what still needs to be done. Which tooth is in place, what still needs to be moved etc.

N.B. It is important that the orthodontist places the teeth a short distance back from the ideal finishing line in order to create the space for the final veneer. This will minimise the amount of tooth preparation required and help ensure the preparations remain within enamel, the optimum solution.

Posteriorly the orthodontist ideally needed to expand the lower arch to balance the occlusion, but this would have potentially extended the clinical time by up to 12 months. Therefore GG needed to discuss this with the patient and orthodontist to get everyone's agreement. The patient was not willing to accept this extension so it was decided not to do this.

'If teeth become properly aligned you frequently get an automatic improvement in the gum profile too'

If teeth become properly aligned you frequently get an automatic improvement in the gum profile too. Therefore by tipping the teeth into a proper alignment you can negate the need for additional soft tissue surgery, but if necessary you can do a crown lengthening procedure.

Once everyone was happy that the teeth were in the correct position, the Lab created a new wax-up and associated silicone template. Then GG created a Luxatemp APT. GG said that he had been using Luxatemp for over five years because it is simply the best, so why would he change.

After the patient had approved the APT, the next stage was to prepare the teeth through the APT. To determine the size thickness of the step-cutter diamond bur depends on the degree of colour you want to achieve. If you use the tree-type step-cutter it needs to be angled in three different planes to get the perfect reduction – apical, middle and incisal angulations. Then remove the APT and finalise the margins etc using a fine diamond bur, preferably under a microscope which enables margin preparation to perfection. All of this results in minimal preparations, with the main reduction interproximally to allow for a proper wrap-around of the veneer. Finish final preparations with a hard polishing disc so that you can make adjustments chairside if necessary. DT

Look out for the final part in the next issue of DTUK

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Dental contracts and the BDA

Neel Kothari interviews John Milne, Chair of the BDA's General DentalPractice Committee

1 What are we likely to expect from the new dental contract?

At a very basic level, I think we can expect something that is much more focused on prevention and providing care that moves us away from the current system which is based on targets. That would be a significant and very welcome shift.

The detail of what it will look like is still being honed of course, but I think there are some very strong indicators of what can be expected. It's clear that the new system will be founded on a detailed assessment of patients' current oral health and risk factors for disease in the future. That assessment is expected to be part of a shift that sees patients better understand how they can maintain their own oral health; more of a partnership between the practitioner and patient.

We can also expect a change in the way the contractual arrangements are underpinned to a system that is capitation based. Those two things go hand in hand of course – if dentists are really to improve patients' oral health in the long term as they wish to then long-term relationships are important. Capitation is a system that underpins that kind of approach in a way that episodic care simply does not.

With the move to capitation I think we can expect to see a recognition that managing patients' recall intervals is vital; managing an entire patient base effectively will undoubtedly mean that seeing people at appropriate and necessary intervals will become crucial. The indications from the pilots thus far seem to indicate that can be made to work.

I think what we can – and indeed should expect – is that new arrangements happen. The Minister, Earl Howe came to BDA Conference in Manchester in April and made a very firm statement that commitment to change remains intact, and he also set out a timetable for moving the process forward from what he described as the piloting of discrete elements of a new system to the testing of prototype whole systems. That was good. I was also pleased that he made the time to attend one of the sessions I led on the pilots – that gave him a chance to hear the comments and questions from the dentists that came along. But promises only mean anything if they are kept, and they must be.

2. How would the BDA judge whether any new NHS system was successful?

I've said all along that the new arrangements must work for practitioners, patients and Government alike. They won't be successful if they don't.

From the profession's point of view I think there are several markers that can be used to assess whether a new system is successful. It must be a place in which practices are sustainable and financially viable – if they are not the estate on which the provision of care is based falls down. And practitioners must be able to care properly for each patient; the ability of practitioners to deliver appropriate care has to be a marker of a good system.

And across the whole patient base I think a new system will be judged on whether it does what it is fundamentally intended to: improving patient health. If the new arrangements are to be judged a success in the longer term they will have to achieve that improvement.

For individual practices and practitioners I think financial viability is key. Practices rely on people investing in them so they must remain profitable and dentists' salaries must be appropriate to the skills and training they bring and the personal investments they make. If practices go bust and a career in dentistry becomes unattractive, the future starts to look very bleak.

And I don't think we should underestimate the importance of dentists being happy; a new system should be one in which dentists are confident they can provide the care they know patients need. The changes of 2006 didn't deliver that; these must. I've stressed that to the Minister and civil servants on many occasions; nobody wants to see a mass drift of practitioners away from the NHS and another spate of patients queuing around the block to access dental care, but if the new system doesn't deliver that's a very real danger.

3. Given the impact of austerity, can we really expect high quality care to be funded within NHS dentistry?

I think we should always expect high-quality care to be properly supported. Dentists are inherently ethical and conscientious and that's what they want to provide; even in a cash-limited system I don't believe dentists set out to provide poor quality care. But there's no escaping the fact that quality costs money; whichever way pots of money are juggled, the size of the pot matters and at the moment the pot is not big enough. Constantly squeezing an already inadequate pot is, obviously, counter-productive.

Looking forward to new arrangements, we also need to think about how the pot is spent. I think there is some challenging thinking to be done. What we are broadly seeing is that younger patients – for the sake of argument let's say the under 40s – require less treatment than older patients, the cohort often termed 'the heavy metal generation', do. And that pattern suggests that patients' needs will continue to evolve, because those younger patients will grow up to be older patients who require less treatment. That's a potentially-significant shift – both for what's required of us as practitioners and for the way care is financed – because it could mean less complex and costly treatment being needed. How significant needs to be mod-

elled and better understood of course, but through that better understanding we might reach a new consensus on the shape of funding in which good-quality care for more patients might be provided. This is slightly longer-term of course – in the short term we must be focused on making sure the new arrangements are appropriately financially underpinned – but we need to think long-term too.

4. Is the BDA doing enough to protect dentists from the burden of legislation?

There is no doubt at all that legislation and regulation have been placing a heavier and heavier burden on dentistry over the last decade. I don't think that growing burden is any way a reflection of what is happening in dentistry or that we have been singled out; successive Governments appear to have had an increasingly suspicious and distrustful view of all the professions.

That's the context against which the BDA is lobbying. So for me, it's all about the art of the possible. Is the BDA doing all it reasonably can to mitigate the worst excesses of regulation? Yes, it is. In recent years I think we've made a good case for the CQC to take account of the realities of dental care – as I said earlier we're an inherently professional and conscientious profession and that's very much borne out by the very favourable reviews we have got in successive CQC reports. Other sectors, as we all know, have performed less well. Our message that needs to be taken into account when thinking about the cost basis and requirements of regulation is starting to bear fruit. And I'd also cite the lobbying we did against financial regulation by Monitor as part of the work we did to influence the Health and Social Care Act; we avoided an immediate and potentially-onerous burden there.

The regulation of dentistry – and indeed healthcare generally – is entering a new period of flux now. The publication earlier this year of proposals by the various Law Commissions across the UK has sketched out potential reforms to the way that regulation works – including potentially changed powers for the GDC. Whether those proposals will become legislation is yet to be seen. The BDA will, as ever, be making plain the importance of regulation being effective, proportionate and cost-effective. That's what it should be.

5. Is dentistry really under attack? And what can the BDA do to help?

It certainly feels like it. As I travel the country meeting practitioners at LDC and BDA event for leading workshops on the pilots I have the opportunity to meet thousands of practitioners and hear their stories. Is the experienced dentist who has provided fantastic care for his patients for years but is now so stressed by being unable to meet his UDA target that he is retiring with stress under attack? I think so. Are the dentists who were inappropriately issued with registered manager penalties by CQC being attacked? I think so too. When there appears to be a greater risk of referral to the GDC or litigation by patients are dentists under attack? Again, I think so. Attacks come in different forms of course – when I spent seven hours treating a fifteen-year-old with 21 cavities and got three UDAs for my efforts, the viability of my practice seemed to be under attack.

What the BDA can, and does, do, is to lobby to make our lives better on the one hand, while providing the expert advice and support we need to carry on with our working lives and get through the obstacles thrust into our path. That's what a professional association is for and that's why I'm involved, and would urge every other dentist to be as well. DT

About the author

Neel Kothari qualified as a dentist from Bristol University Dental School in 2005, and currently works in Sawston, Cambridge as a principal dentist at High Street Dental Practice. He has completed a year-long postgraduate certificate in implantology and is currently undertaking the Diploma in Implantology at UCL's Eastman Dental Institute.