

LETTERS TO THE EDITOR

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CHILD DENTAL HEALTH

Fuzzy classifications

Sir, as lecturers in the sociology of oral health we endeavour to instil critical awareness about oral health inequalities among our dental students. Published data sources help us to demonstrate the social patterning of oral health and in turn strengthen our claims as to the social determinants of oral health and the persistence of oral health inequalities.

Previous child dental health surveys recorded child oral health according to a variety of social variables, including household composition and socio-economic status (NS-SEC).¹ However, the 2013 Child Dental Health Survey incorporated a change in the reporting of area classifications to include ONS 2011 output area classification (OAC). These OACs are based on the grouping together of 'similar geographic areas according to key characteristics common to the population in that grouping'.² The role of the OAC is

'intended to be illustrative of the characteristics of areas in terms of their demographic structure, household composition, housing, socio-economic characteristics and employment patterns'.³ As a result, according to the 2013 survey, 22% of 'hard pressed living' children at the age of five in England, Wales and Northern Ireland have severe or extensive dental decay, compared with 18% of 'constrained city dwellers' children aged five, 9% 'suburbanites' and 9% 'urbanites' children aged five.⁴ While a glossary of each of these groups are included in the technical report² we query the empirical utility of these classifications.

The ONS admit that these OAC groups, such as 'constrained urban dweller' and 'urbanites' represent 'the most generic description of the population of the UK'.³ Nevertheless, how we define and measure health is a political act, influencing public opinion of health and health policy more generally.⁵ By using the OAC classifications the distribution of child oral

health is recorded not according to social class but rather to these 'fuzzy' descriptive classifications. This change in reporting makes it difficult to compare 2013 data with previous surveys, which relied on the established socio-economic status classification, having a negative impact on our capacity to assess oral health trends over time and across social groups. As a result, the 'clustering of disadvantage' associated with poor oral health becomes obscured, reducing in turn our ability to monitor the 'health gaps'⁵ that exist in society. The lack of accurate social/epidemiological data will also detract from recent efforts within the dental profession in the UK on how the profession can work to reduce health inequalities and contribute to a more equal society through their delivery of care.

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1. Steele J, Lader D. *Social factors and oral health in children. Children's Dental Health in the United Kingdom 2003*. London: ONS, 2004.

ORAL SURGERY

Mandibular fracture risk

Sir, a 28-year-old male patient presented to our maxillofacial department with an iatrogenic mandibular fracture, confirmed by imaging, following removal of an impacted lower right third molar tooth.

The extraction was carried out under local anaesthetic in a general dental practice where upon delivery of the tooth, both dentist and patient heard 'a crack'. Subsequently, the patient's occlusion was deranged and mobility was evident in the right side of the mandible. The following day, open reduction and internal fixation was carried out under general anaesthetic and the patient was discharged two days post-admission.

In light of the recent changes to the law regarding consent, we feel this case highlights the important implications for clinicians. The landmark decision

in *Montgomery v Lanarkshire Health Board*,¹ given by the UK Supreme Court on 11 March 2015, means that the 'Bolam test' no longer applies to the issue of consent. This previously-used test asked whether a clinician's conduct would be supported by a responsible body of medical opinion. However, the law now requires doctors to take 'reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment'. The definition of a 'material risk' is one to which a reasonable person would be likely to attach significance.

In this case, the risk of mandibular fracture was not discussed with the patient during the consent process. It can be argued that, due to the low incidence of mandibular fracture associated with the removal of teeth (<0.005%),²⁻⁴ this need not be discussed during routine procedures. We believe this is now a perilous attitude in an increasingly litigious world. In the case of *Rogers v Whitaker*,⁵ an Australian court found the ophthalmologist to be negligent

for failure to disclose the chance of blindness due to its remote risk (0.007%). Whilst we respect that the loss of vision is a far greater morbidity than a mandibular fracture, we feel the latter would be deemed of significance by the majority of patients. Our advice is that the rare risk of mandibular fracture is discussed with all patients before removal of lower third molar teeth.

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1. *Montgomery (Appellant) v Lanarkshire Health Board (Respondent) (Scotland) [2015] UKSC 11*.
2. Alling C C, Alling R D. Indications for management of impacted teeth. In Alling C C, Helfrick J F, Alling R D (eds). *Impacted teeth*. pp 46-64. Philadelphia: W B Saunders, 1993.
3. Perry P A, Goldberg M H. Late mandibular fracture after third molar surgery: a survey of Connecticut oral and maxillofacial surgeons. *J Oral Maxillofac Surg* 2000; **58**: 858-861.
4. Libersa P, Roze D, Cachart T, Libersa J C. Immediate and late mandibular fractures after third molar removal. *J Oral Maxillofac Surg* 2002; **60**: 163-165.
5. *Rogers v Whitaker* (1992) 175 CLR 479.