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Priority will be given to letters less than 500 words long. Authors must sign the letter, which may be edited for reasons of space

Child abuse referral warning

Editor's note: we apologise to Dr Hussain and to our readers that this letter was not printed in its entirety in BDJ *2006;* ***200****: 475.*

Sir, I write to you with the hope and possibility that you may raise this awareness through the columns and letters section of the *BDJ* with regard to problems I have had with a suspected case of abuse of a family of four children.

I had been seeing a family with four children for several years and over the last few years had noticed that the children had become very, very withdrawn and not connecting socially on their visits to see me. I had further noticed and observed that the father had an alcoholic problem and had seen him around the area of my practice on several occasions in a clearly drunken state. On two occasions he came to appointments with a distinct smell of alcohol on his breath.

When I recently saw some of his children for treatment I began to worry about their state of withdrawal and decided to alert Social Services, having observed this. I was aware of the fact that all professionals have a duty to inform the appropriate authorities if there is a concern about the welfare of children but was not aware that we can make this awareness known and maintain our anonymity when making a referral. However, in this case when I made an initial enquiry with the Social Services, the family were known by the Social Services and was on a monitoring register. I was promised that they would maintain my anonymity as they said they would just re-open the case and visit the children to see how they were.

I was horrified some two months later when one of my practice staff informed me while I was away that the father had made an approach to the practice and was very verbally abusive and aggressive to them (I hadn't informed any of my staff of this referral). This seriously worried me as the father had been aggressive and abusive in the past and I was worried about the security of my practice staff. I immediately contacted Social Services who informed me that they'd had to tell the parents who had initiated the referral and therefore my anonymity was blown and it compromised the security of my staff as well as myself. I was informed by Social Services that the health and wellbeing of a child is far and above the welfare and security of a practitioner or his staff and premises and because of this they'd had to inform the parents who had made the referral. I was shocked to hear this and had I known this in advance I would have made another approach to the Services to try and maintain my anonymity and the welfare of my staff.

Would you kindly raise awareness through your columns that, if there is concern about the wellbeing of children, before making any referral, practitioners need to realise the implications of what happens when you make referrals under the Child Protection Act in abuse cases and that there must be some form of avenue where we can make referrals without compromise.

M. Hussain
London

Professor Tim Newton and Dr Elizabeth Bower offer some guidance: *The incident described by Dr Hussain demonstrates the complexity and difficulty of the management of suspected instances of abuse or neglect. General dental practitioners faced with a situation such as this will need to consider the welfare of the children involved, their personal safety and that of their staff. Clearly there is a moral imperative to protect the children at risk. Guidance on what to do in cases of suspected abuse is relatively clear;*[1,2] *practitioners can phone up and ask whether a child is on the child protection register (and if the child is on the register, the social worker will be informed of the enquiry) and/or discuss the case of a child with Social Services without disclosing the child's name. However, if they make a referral (even if this is relatively 'informal'), it is suggested that the practitioner obtains the parent's consent unless it is judged that discussing concerns with the parents would place the child at risk of significant harm. Sharing information after refusal of consent is only appropriate if the child's welfare overrides the need to keep the information confidential. Of course it can be difficult to judge the harm that may arise from speaking to a parent, and it is not a pleasant task, however a parent who is asked about their children's social withdrawal may respond differently to one who finds that they have been referred to social services without their knowledge.*

Balancing the risk of harm to the child and the risk to the staff of the practice again requires the practitioner to enter in discussions which are probably outside the normal range of general practice. Dentists and staff working in the practice will be protected by the law on assault, and practices should develop guidance on the management of threatening behaviour. A key element is communication within the team, and the development of clear guidance on dealing with problems of this nature.[2] *In a busy practice setting, it is easy to hope that what are, thankfully, relatively uncommon occurrences can be managed as and when they occur. However the development of protocols for handling difficult situations can ensure that a response, when needed, maximizes the beneficial outcomes and reduces the risks.*

1. Department of Health. *What to do if you're worried a child is being abused.* UK: HMSO, 2003.
2. Bower E, Harrison V, Newton T *et al. The management of abuse: A resource manual for the dental team.* London: Stephen Hancocks Ltd, 2005.

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Lost data

Sir, readers of *Dental Update* will have noted that my views, expressed in an editorial three months ago,[1] and more recently[2] were similar to those presented by your good self in your recent editorial, *Data day* (*BDJ* 2006; **200**: 301), which succinctly and emotionally stated that 'a powerful source of data is to be smothered'. It beggars belief that the collection of data for administrative and research purposes at the Dental Practice Board has been stopped, to be replaced by the untested Units of Dental Activity, which measure little. No longer will practitioners have the ability to measure the longevity of their restorations, surely a basic tenet of clinical governance. No longer will researchers be able to demonstrate, as they have done recently[3] that the public in England and Wales has been most cost-effectively served by their NHS dentists. Indeed, NHS dentistry has been the envy of much of the developed world.

My Masters students presented SWOT analyses of their practices early in December 2005. Having listened to their

anxieties about the changes to NHS dentistry, I was moved to write to the Prime Minister. In the letter I expressed my serious disquiet that the new arrangements would not please patients, who will often have to pay more and will not have improved access (who in their right mind will take on a patient requiring extensive restorative treatment under the new arrangements?), that they would not please dentists who will still be on a treadmill (meaningless UDAs) unless they have inflated their gross in the historical period. Moreover, the new system does not measure oral health, which surely it should. The reply took three months, an indication, surely, of a serious lack of interest in the new arrangements from Downing Street, perhaps hinting that the new arrangements are a back door means of pushing dentists into the private sector. A rationalised fee per item to allow new attendees to achieve oral health prior to entering into a capitation system would have solved many of the problems of GDS and nGDS, or payments linked to improvements in oral health, which is now readily measurable by means of a tried and tested Index.[4] While there was no question that the 400+ fees in the GDS required rationalising, the abandonment of meaningful data collection seems like folly.

F. J. T. Burke
Birmingham

1. Lost data. *Dent Update* 2005; **32:** 501.
2. Is anyone happy? *Dent Update* 2006; **33:** 5.
3. Lucarotti P S K, Holder R L, Burke F J T. Outcome of direct restorations placed within the general dental services in England and Wales (Part 1): Variation by type of restoration and re-intervention. *J Dent* 2005; **33**: 805-815.
4. Burke F J T, Wilson N H F. Measuring oral health: an historical view and details of a contemporary oral health index (OHX). *Int Dent J* 1995; **45**: 358-370.

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Fire-fighting disease

Sir, we would like to support our hospital colleagues, Messrs Carter and Starr, in their letter *Alarming increase in dental sepsis* (*BDJ* 2006; **200:** 243). As members of the salaried dental services in Hull and East Riding, the level of dental disease in our area has increasingly shocked us over recent years. It is comparable to levels in East London in the early 1980s, when facial swellings were admitted to hospital, at least weekly, for intervention under general anaesthesia. We are at present developing an audit and protocol for facial swelling and are liaising with the maxillofacial team at Hull Royal Infirmary for verification and guidance.

From our experience, although many patients who present at our dental access centres rarely visit a dentist, a significant number of patients that present with facial swelling have lost their GDP through retirement or to the private sector.

On a general note, the level of caries in the population that attends our centres is staggering, often with 10 or more carious teeth, frequently with significant medical histories. It is not unusual to meet children who have never been able to access dental care, despite trying to. Our perception is that we tend to see acute necrotic ulcerating gingivitis on a weekly basis in our clinics.

As stated by Messrs Carter and Starr, this part of England has an unfavourable dentist:population ratio – a situation which has endured for many years. To alleviate this problem, a network of dental access centres was built in Hull and the East Riding of Yorkshire over the last five years. From the start, it was evident that there was a huge demand for this service from patients seeking emergency and routine dental care.

Although we prioritise patients with urgent dental needs, we are not *per se* an emergency dental service. The access dental service has increased patient contacts in the area by upwards of 40,000. This service is complemented by an out of hours emergency dental service with centres in Hull, Bridlington and Goole, which deals with about 14,000 patients per year. Even with these services, we are 'fire-fighting' with no apparent bottom to this well of dental disease. So why have we not solved the problem of access for our local population and why are more and more patients presenting themselves at the local A&E department with acute dental problems?

Firstly, we still have too few NHS dentists to provide treatment for the population, with many dentists closing their NHS lists and some shifting to the private sector. This has been balanced, only slightly, by the opening of a number of dental practices, mainly by dentists already working in the area.

Secondly, there is a large section of the population who only seek dental treatment when needing pain relief. To a certain extent up until 2001 in the Hull area, their needs were catered for by easy admittance to dental treatment under general anaesthesia. These patients will invariably leave their acute situation until a very late stage of deterioration or morbidity and will perceive that their dental needs are best suited at a hospital. While we applaud the reduction of general anaesthetics in Hull, little by way of an alternative has been provided locally, possibly due to lack of specific funding.

We cannot see any immediate solution to the shortage of NHS dentists and are fearful that, as Lester Ellman predicts, the new contract will not improve access for patients.

Are we a predictor of the future of NHS dental care in England?

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Unwise deductions

Sir, I write to comment on the news article *Oldest recorded case of impacted wisdom teeth* (*BDJ* 2006; **200**: 311). It is stated that the radiograph of a female illustrating the item shows an impacted wisdom tooth. Various deductions are then made from this bit of evidence as to the age of the person and to the effect of her diet.

The wisdom tooth shown is not impacted. It is merely unerupted and developing. It is not in contact with the second molar anterior to it. The crown is fully formed and the root is just beginning to show some calcification.

Third molars (wisdom teeth) are the least useful for estimating age as they have the greatest variability in development and eruption. The apex of the second molar appears to have closed suggesting a lower age of 15 years. The wisdom tooth development suggests an age between 15-17 years. The original conclusion that she was a 'girl' rather than a young woman of between 25 and 30 years old was much nearer the mark. The latter age estimation, based on a misinterpretation of the radiograph, is most unlikely to be correct.

The scientists at the Field Museum, where the jaw is retained, will be able to use visual clues such as attrition etc, to estimate her age and reconcile them with the important radiological evidence.

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Correcting parafunction

Sir, I was concerned with some of the statements made in the first of the series on the *Vertical dimension* by Bloom and Padayachy (*BDJ* 2006; **200**: 251-256). Following the introduction of specialist registration in 1999 there has been a tendency for those with special interests to downgrade the abilities of the general dentist and I felt uncomfortable with phrases such as 'adequate training must be considered essential'. All dental students should have had an adequate basic training and be capable of moving on from there by responsible self education and experience.

The authors provide some good information but those who assume specialist roles need to be especially careful to avoid unwarranted assumptions. For instance it is misleading to say that 'there is no evidence to suggest that by changing VD one can treat TMD'. As the authors are well aware, short-term relief of TMD is commonly achieved with bite splints. It is also unlikely that 'the vertical dimension of occlusion is determined by the repetitive contracted length of the closing muscles' as we know that the vertical dimension may change dramatically following full extractions, suggesting that oral volume and other feed back mechanisms can override muscle length.

Unfortunately there is little consensus about why some bites are overclosed in the first place. The most obvious contender is a tongue-between-tooth posture, but no one has yet found a reliable method of measuring this. Such parafunction is difficult to correct, especially in adults, and a long-term splint plus a persistent tongue-between-tooth posture will frequently lead to further intrusion of the teeth. We cannot afford to continue to ignore a major factor just because it is not measurable. It may well be the prime cause of many if not most occlusal and orthodontic problems.

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Snow-white teeth

Sir, everyone must admire the clinical skills – and ceramic specialists' technical work – needed to achieve the smile lifts portrayed in Bloom's and Padayachy's recent excellent and splendidly illustrated articles (*BDJ* 2006; **200**: 135-138, 199-203.)

To my eye, however, more and more media celebrities betray the fact that they have commissioned services like these. The reason is that their supposedly pristine dentitions are too white; facial attractiveness, they appear to believe, is proportionate to the whiteness. Nevertheless I fancy that practitioners specialising in sophisticated cosmetic up-lifts have striven to persuade them otherwise, and may well have pointed out, but unavailingly, that snow-white teeth adorn only the grins of infants.

There is, however, another ploy that colleagues might try in their quest to enlighten patients, particularly those of a literary disposition: adduce the attributes of 'youthful beauty' given to us by Virginia Woolf (1882 – 1941). From her novel, *Orlando* (1928), here is a short, but pertinent item from the extensive catalogue of 16-year-old Orlando's beauty: 'The lips themselves were short and slightly drawn back over teeth of an exquisite and almond whiteness'. If the personalities I have in mind were to draw back un-thickened lips over 'Orlando' teeth only their mothers and, of course, our colleagues, would know that their provenance was other than genetic.

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An amicable divorce?

Sir, recent correspondence in the *BDJ* wrongly equates oral surgery with being only dentoalveolar surgery. What oral surgery consists of should be clarified, and thus a clear view of its future role in the NHS can be developed.

Oral surgery falls under the EU dental directives and allows oral surgeons to carry out procedures similar to OMFS apart from oral cancer, and facial deformity. With appropriate training, competencies include fractures of the facial skeleton, treatment of the TMJ and other jaw anomalies, and salivary gland disease. Your previous correspondents may be interested to know that no matter how high GDS tariffs go, these oral surgery procedures are unsuitable for the primary care sector. With current shortfalls in service provision, there is a strong argument that dentally qualified oral surgeons can provide a valuable consultant led service for the population. With cancer, and cleft lip/palate services being centralised, the extra training that maxillofacial surgeons have undergone can be effectively used in tertiary referral centres. Oral surgeons can thus provide the full range of oral surgery in a consultant led service.

Is there an argument then for a 'divorce' between oral and maxillofacial surgery? Under modernising medical careers, the length of SPr training will be reduced, and I suspect that a four-year programme is insufficient to encompass the whole of oral and maxillofacial surgery. By separating the two specialities, dental graduates can be trained in the complete remit of oral surgery, and medical graduates in maxillofacial surgery, giving both specialities the important training and experience they deserve. The argument that leaving out one undergraduate degree may miss conditions is invalid in the current age of multi-disciplinary team working as well as working within one's own area of competence. Apart from occlusion, and diagnosis of dental pain, it is hard to see why a medical graduate wishing to pursue maxillofacial surgery requires a dental degree.

Hopefully, the re-organised SAC in Oral Surgery will investigate these matters in a positive and constructive manner. The RCS England's current report *Developing a modern surgical workforce* Jan 2005, (Table p.13) indicates consultant shortfalls in OMFS currently (103) and the predicted shortfall in 2009 (212). This significant shortfall is not due to any dramatic increase in demand for oral cancer or facial deformity.

An attractive training pathway can thus ensure that the demand for a consultant led service in oral surgery can be met, and would no doubt be popular with dental graduates and oral surgery departments.

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