Antibiotic resistance

Antimicrobial stewardship and the anxious patient

Sir, the current issue of antimicrobial stewardship is an important and necessary aspect of healthcare in which we as dentists have a crucial role to play.

The BDA, FGDP and Public Health England have launched action plans to tackle this issue of antibiotic resistance, and require healthcare professionals to be engaged.¹

Without urgent action, there is a real threat of entering a post antibiotic era as antibiotics are becoming less effective.²

As guided by NICE, we must avoid overuse and misuse of antibiotics.³ Ensuring appropriate use of antibiotics is crucial to preventing resistance and protecting patients, as well as cutting down unnecessary costs. We must continue to educate our patients about resistance, and why prescribing may not be the ideal treatment modality compared to local intervention.

Standard 1.4 as outlined by the GDC, advises us to provide patients with treatment that is in their best interests, following clinical guidelines relevant to their situation. We are advised to balance their oral health needs with their desired outcomes.

A recurrent difficulty faced by many practitioners is management of anxious patients. These patients simply cannot tolerate any conventional interventions, such as incision and drainage of a swelling, access through the tooth, or an extraction.

This cohort of patients presents practitioners with what at times appears an insoluble problem – where the patient demands are in conflict with ideal local treatment. This leaves us with an ethical dilemma – although patients have autonomy to deny treatment, to leave a patient in pain or with a swelling is both unethical and unacceptable. This could lead to deterioration in health with potentially serious consequences.

Recent media attention, and campaigns developed by the FGDP have been invaluable in educating patients on how ‘antibiotics don’t cure toothache’.

However, whilst time invested in education of the patient and advice regarding their role in antibiotic stewardship is important, the present contracting arrangements within primary care make this challenging.

With time limitations, stressful UDA targets and ever-increasing patient demands,

dentists may feel backed into a corner. One might question what alternatives exist to manage an anxious patient that presents in a time-limited pain slot.

*K. Smorthit and T. Thayer, Liverpool, UK,
by email*

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Stress

Emotional burnout

Sir, burnout scores for emotional exhaustion in UK doctors¹ and the recent paper by Toon *et al.*² indicate that many dentists suffer bad stress due to organisational and personal factors. It is surely urgent that research focuses on how stress pathways develop throughout medical careers.

Taking note of studies in dental education which look at the development of professionalism could well be a good way forward.

Strong reactive emotions in dental students such as fear, frustration and shame have been found to be associated with challenging patient encounters and taking more responsibility for care.³ In my experience, many foundation dentist peers find these sorts of strong emotions can really hinder us, yet are often hard to admit for fear of being seen as weak.

The culture in medicine is hopefully now changing towards accepting that emotional sensitivity is part of being a good dentist. Current anti-stigma campaigns also attempt to reduce barriers to admitting stress or illness in medics and dentists.⁴

If research looks into our emotional reactions to provide more of an understanding of dentists’ stress drivers, and if the medical culture can adapt, burnout rates may start to fall.

*R. Bernstein, Budleigh Salterton, UK,
by email*

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LGBT+ recognition

Why I refuse the rainbow lanyard

Sir, I have been asked to consider wearing a rainbow lanyard at work ‘to send a clear message of support to the LGBT+ community’.¹

My gut reaction was to agree, to help increase visibility for a community I support. I firmly believe in equalities in health and so on first glance this appears like a very worthy idea, especially when considering that more than 20% of LGBT+ people feel uncomfortable being open about their sexual orientation or gender identity with NHS staff.²

There was, however, an underlying discomfort in me about the request that I feel warrants discussion. I became concerned about the potential distress to other patient groups caused by such a personal display of support for the LGBT+ community, with an item worn in the clinical setting.

When I referred to the GDC Standards³ I found that Standard 1.6.4 states: ‘You must not express your personal beliefs (including political, religious or moral beliefs) to patients in any way that could cause them distress’.

Whilst 2% of the UK population identifies as lesbian, gay or bisexual,⁴ the last census found 59% of the population identifying as Christian.⁵

The dominant Christian churches in the UK are clear on their stance towards homosexuality. The Church of England – the state religion of England – maintains that homosexuality is ‘incompatible with Scripture’,⁶ and in a 2017 interview the Archbishop of Canterbury, Justin Welby was unable to answer whether gay sex is sinful.⁷

The Roman Catholic Church asserts that homosexuality is a ‘strong tendency ordered toward an intrinsic moral evil; and thus the inclination itself must be seen as an objective disorder’.⁸

It should come as little surprise then to find that 25% of Christians disagree with same-sex marriage,⁹ and that 12% of the

population would be uncomfortable knowing that their GP is lesbian, gay or bisexual.¹⁰

It would be rightly unacceptable for fervently religious clinicians to wear a lanyard in a clinical environment that demonstrates their belief that gay sex is a sin, or that demonstrates their disapproval of same-sex marriage.

However, in deeming that unacceptable, I feel compelled to challenge the new social norm of demonstrating the opposing view with a lanyard in a clinical setting.

This makes it clear to me that what is important is less about the worthy reasons why I might be sporting a rainbow lanyard, and more about how that item might be interpreted by certain patient groups, and in particular whether it could cause any distress.

I want to ensure LGBT+ patients feel comfortable in the clinical setting just as much as those who might be opposed to same-sex relationships on religious grounds. Both groups have a right to be treated in a non-judgemental and non-prejudiced space.

I conclude then that LGBT+ patients can, and should, be helped to feel more comfortable with posters or leaflets in a waiting area, but a dentist's surgery should remain an apolitical space that is solely focused on patients' oral health concerns.

S. Worthington, Edinburgh, UK, by email

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Education

Novel integrated curriculum

Sir, it is commendable that those responsible for creating and delivering such a course as detailed in a recent *BDJ* paper should be praised for their work.¹ However, we wish to put the record straight.

This course is not the first such course to integrate the education and training of dental hygienists and dental therapists with those of the dentists.

The London Hospital Medical College (LHMC) Dental School, now known as the Institute of Dentistry, Barts and The London, Queen Mary University of London, introduced integrated teaching of the dental hygiene and dental therapy course and the BDS course in 1983. A brief description of how this came about will be a timely reminder of pioneering historical events.

When the School for Dental Therapists at New Cross in South East London was due for closure in 1982, the then Professor of Conservative Dentistry – the late Professor Harry Allred – proposed to the Department of Health to set up a new type of dental hygiene and therapy training programme as its successor. The curriculum at New Cross School was modelled on that of the School Dental Nurses' curriculum in New Zealand (The School Dental Nurses are therapists and their work is invasive in nature).

This proposal was accepted by the Department Health and funding was made available to set up the Dental Auxiliary School (DAS) at the LHMC under the Directorship of (Professor) Stuart Morganstein.

The first cohort of eight students was admitted in 1983. The unique feature was the integration of teaching of dental hygiene and therapy and the third year of the BDS course. Each student group consisted of BDS students and dental hygiene and therapy students, who had the same lectures, seminars, practicals, clinicals and assessments. They also carried out projects together which were presented to a whole school audience once a year.

Both groups of students benefited from this integration and also dispelled fears among future dentists that the dental therapists were a threat to them and could be an asset in practice. This was at a time when there was much opposition among the dental profession to the introduction of the hybrid of a combined dental hygienist and therapist.

The underlying philosophy was that although the remit of dental hygiene and therapy was specific to a defined scope of practice, the public expected the same high standard of care as practised by the dentists whose remit was wider. Therefore, the dental hygienists and therapists needed to be educated and skilled to the same standard as that for the dentists.

In addition, a 'team in training' approach to education was expected to lead to a harmonious 'team in the workplace'.

Obviously, the two groups had separate specialised teaching also, but the underlying principles were integrated teaching of BDS and dental hygiene and therapy students with Years 3 and 5 of the BDS curriculum. Inter-professional education was at the core. Two other directors of the DAS, Professors Elizabeth Davenport and Kevin Seymour contributed to enhancing inter-professional education even further.

Over the years, many other schools in the UK adopted the same philosophy and adapted this method as a basis for shared teaching and learning activities.

The Diploma in Dental Hygiene and Dental Therapy is becoming a BSc programme at Queen Mary later in 2019, but the original concept of integration with the BDS course continues, as in the past. The Queen Mary model has many features as described in the article referred to, therefore it is not necessary to describe them in detail.

This letter is only to put the record straight. We do not wish to devalue the efforts made by our colleagues at the Peninsula Dental School. In fact, we commend them for adopting a revolutionary concept pioneered 36 years ago and now applying a focused approach within assessment.

S. Murray, J. Holt and D. Y. D. Samarawickrama, London, UK, by email

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