The incidence of permanent nerve damage from inferior alveolar nerve blocks has been reported as being from 1 in 20,000 to 850,000.[2] While the risk and consequences of this should not be disregarded, it hardly seems comparable to other never events, for example removal of the wrong kidney.

Although the reporting of never events is supposed to encourage learning from mistakes rather than blame, the anecdotal evidence is that they have stigma attached to them and are incredibly stressful for the dentist involved.

It should be noted that the reason given for removal of wrong site dental blocks was that 'systemic barriers are not strong enough to prevent these types of incidents from occurring',[1] rather than the generally reversible nature of the mistake. However, it is still encouraging that dentists' concerns were listened to and that common sense has prevailed.

C. Docherty, Newcastle-upon-Tyne, UK

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https://doi.org 10.1038/s41415-019-0763-z/

Dental careers

Costs and expenses

Sir, I write to support a recent *BDJ* article entitled *Are researchers paying too much for dental meetings?* (*BDJ* 2019; **226:** 927-929) from a student perspective.

The authors draw attention to the high and ever increasing fees for participants presenting research findings at dental meetings. Scientific meetings present valuable opportunities for networking and research interaction. The importance of research is emphasised in the undergraduate dental curriculum and students are encouraged to attend and share their projects at conferences. Such opportunities can foster motivations towards a career that includes research. However, conference fees present a significant challenge impeding student attendance and participation.

For many students, undergraduate years are a time when finances are stretched. It must be acknowledged that some conferences do offer discounted rates for student attendees, but these often remain costly. Expenses do not end with registration; printing of posters, subsistence, and travel to conference venues can all add up to surpass the standard student budget. To cover these additional expenses may simply not be possible, especially for students from lower-income backgrounds or who have carer or childcare responsibilities. High fees risk creating an even greater disparity between those students who can and those who cannot afford to attend meetings, yet this is not a criterion to be a good researcher.

Despite frequent inclusion in the 'early career researcher' category for conference registration (and payment), undergraduate students are not eligible to apply for funding from the same grants. While institutional support with costs is an alternative for undergraduates, this is variable and can range from a deficient subsidy to non-existent. Given that funding is limited, staff and researchers who are more established on the career ladder should be prioritised. Student researchers may not bring the same levels of research experience to the table, but costly conference fees and lack of financial support risk excluding students entirely. Are students not encouraged to become the future of these scientific meetings and research conferences? I fear that such costs will rule out, or even deter students from including research in their future careers.

J-Y. S. Yeung, London, UK

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GDC regulation

Erasure

Sir, Dr Bishop (*BDJ* 2019; **227:** 4) draws attention to the reluctance of the GDC to define how serious an offence should be to warrant the removal of a licence to practice. It is accepted that this penalty should be reserved for very serious offences, and the protection of the public.

Despite the bankrupting and professional consequences most dentists would consider this fair. Last year my licence was removed after a patient's mother said I had told her that orthodontic treatment might damage her daughter's face and that I could improve her face. There was no suggestion that I had harmed the patient in any way or that I should refund fees.

Subsequently I sent a copy of my consultation letter to a number of dental colleagues asking if they thought I had been fair. This letter had already been through the County Court and therefore was no longer legally 'confidential'.

The GDC initially suspended me because I had misled the patient and subsequently removed my licence for lack of confidentially. There were other minor issues which I had strongly contested. What was my offence? Apparently disagreeing with orthodontists from the United Kingdom who claim that it is not possible to change faces for the better or worse.

Internationally there is considerable support for my approach and 32,000 dental professionals have become members of my Facebook site as well as 5,000 'friends'.

J. Mew, Broad Oak, UK

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Dental pain

Painkiller overdoses

Sir, I wish to emphasise the importance of checking for painkiller overdoses whenever a patient presents with dental pain.

An 18-year-old recently attended with toothache. On checking self-medication, over the course of several hours he had taken: 12 x 500 mg paracetamol tablets, 10 x 30/500 mg co-codamol tablets and 4 x 30 mg codeine tablets: ie at least 11 g paracetamol and 420 mg codeine, far above the maximum doses of 4 g and 240 mg. A quick call to the local A+E department confirmed his need to be seen urgently. However, the patient did not share this urgency stating he 'did not fancy a four-hour wait' and would go to his GMP in a few days.

Patients with dental pain frequently accidentally overdose on painkillers with a recent study in the *BDJ* reporting 37% presenting to an A+E department and concluding that this was due to a lack of patient awareness of the potential overdose dangers and inadequate access to dental services.[1] In this case the patient had seen an emergency dentist the previous day who advised painkillers but crucially did not advice on dosages.

The former conclusion is however certainly true. The patient overdosed to help him sleep as 'a few tablets weren't good enough'. As they are easily accessible medications he felt there was no danger in taking more than stated on the box. The effects of an overdose often don't present for several days making patients unaware of the potential harm they have caused. This lack of symptoms was also a deterrent from attending the local hospital when advised.

Teaching on basic pain history includes asking patients if they have taken painkillers and how many. Yet do we all do this? Perhaps

this relates to the time pressures of NHS dentistry - the practice I work in has 15 minute appointments for an 'Emergency Pain' which appears to be the norm in the area. Is this really enough time to take a full and detailed history as well as examining the patient, performing any investigations and then treatment?

Despite time pressures, this patient reinforced in me the importance of ensuring patients are asked regarding doses of painkillers taken; and when advising painkillers, ensure patients are made aware of the dosage and if needs be the consequences of an overdose.

In order to act holistically, these two quick and easy points should be followed as a matter of routine. After all, taking it to an extreme, the seconds needed to address these simple points have the potential to save someone's life.

A. Swansbury, Newcastle, UK

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Restorative dentistry

Prostheses in Parkinson's disease

Sir, I enjoyed reading the *BDJ's* recent paper on the restorative options available to partially dentate/edentulous patients with Parkinson's disease (PD).[1]

Implant-retained mandibular overdentures are argued as the minimum standard of care in improving denture retention and stability in edentulous adults.[2] However, Kaka *et al.* acknowledged high costs, the risks of aspiration (during implant placement) and the potential poor long-term survival of these restorations in patients with dyskinetic parafunction habits.[1] It is also important to consider the often overlooked decline of a patient's oral, physical and mental health before offering advanced restorative treatment.

Parkinson's disease is a progressive disorder, where cognition and control over movement continue to decline with age. This creates barriers to good oral health that include dementia, dysphagia and a reluctance to cooperate with carer-assisted oral hygiene, eventually leading to a deterioration in oral health and the need for domiciliary dental care; complicating the long-term maintenance of implants and the supporting periodontium.

Alternatively, although providing a 'wearable' tissue-borne denture can be difficult even in cooperative patients, a good knowledge of a) impression materials (well-tolerated fast-setting alginates and silicones), b) the denture-making process (using acrylic base plates when assessing retention and stability at the occlusal registration/try-in stages) and c) the denture-bearing area (engaging the retromylohyoid space in improving the stability of a lower denture), is invaluable which, when the need for adjustment or repair arise, is better managed when in the domiciliary setting.

From the viewpoint of a dental student, it is important to be pragmatic in your long-term approach to restorative dentistry when treating elderly patients with complex needs as a more simple option, though arguably not the 'minimum standard', may be in the patient's best interest.[2]

A. Farrow-Hamblen, Carlisle, UK

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https://doi.org/10.1038/s41415-019-0759-8

Global policy

Beyond the dental silo

Sir, we read with interest and a degree of amusement the recent editorial from our worthy *BDJ* editor-in-chief who, in his customary style, raises some interesting points which we would like to address.[1]

First, we would like to thank him and the senior BDA staff for attending and participating in the recent UCL-*Lancet* launch event to mark the publication of the Oral Health Series.[2,3] They joined an international audience who enjoyed presentations delivered by the co-authors and a lively discussion from an invited panel of leading policy advocates.

We feel it is important to explain the background to *The Lancet* series which was commissioned by the editorial team recognising their neglect of oral health. Such series are intended to provide an overview and introduction of a topic, and while not new to a dental readership the subject will certainly be so to *The Lancet's* global medical and policy audience.

Dr Hancocks rightly acknowledges the high esteem of *The Lancet*, its influence and its global policy reach. It is surprising therefore that he bemoans their interest in setting forth a future agenda to address the global neglect of oral health. Sometimes outsiders are best able to see the way ahead rather than those of us who are too narrow and fixated with the minutiae of oral health.

It is incorrect of Dr Hancocks to state that the overriding message of the series was that 'individual treatment was no longer the way forward'. We call for radical reform of oral health care systems to enable clinicians to deliver high quality and appropriate care to their patients, combined with policy changes to promote population oral health and reduce inequalities. It is also important to acknowledge that the issues raised equally apply to high- middle and low-income countries. In the UK many positive developments have occurred in oral health and dentistry in recent years. However, many challenges remain. Our population still suffers from a significant burden of oral diseases; we have persistent inequalities in oral health across our populations; and many in the dental profession are dissatisfied with their NHS contract. Oral health systems across the UK require urgent reform to enhance prevention, promote greater equity and access, deliver high quality care, be better integrated with the wider NHS, and improve staff morale and wellbeing.

Following publication of the series the authors are now in discussion with *The Lancet* to discuss options for a Lancet Commission on Oral Health which would bring together dental, medical, members of the public and policy experts to further develop a detailed action plan for oral health. A video of the launch event is available at: www.ucl.ac.uk/dph.

R. G. Watt, London, UK
B. Daly, Dublin, Ireland
M. Mathur, Liverpool, UK
H. Benzian, Berlin, Germany
L. M. D. Macpherson, Glasgow, UK.

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