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Coach mentoring

The struggle within

Sir, Shaun Sellars deserves congratulations for his recent article in the Upfront section of the *BDJ*.[1] His sentiment that we as a profession need to become more compassionate towards our fellow colleagues is strongly supported by research being conducted at the University of Portsmouth Dental Academy. We interviewed 11 qualified dental coach mentors and used a qualitative approach to analyse their experiences of helping members of our profession in difficulty.

The mentors discussed mentee-related themes including: (i) the need for non-judgemental and confidential support; (ii) someone to listen to their story when things have gone wrong; and (iii) support to help them reflect on where they find themselves and how they can develop into reflective practitioners.[2] With reference to the 'kintsugi effect' of broken pottery being repaired with gold, coach mentoring can play a valuable role in helping dentists in difficulty to gain self-awareness and reflection. This is the gold that nurtures our broken colleagues.

Dentists falling foul of regulatory processes are not necessarily 'bad' people. Life often just snowballs out of control and a structured action plan is needed to allow the mentee to develop. Conditions imposed by the regulator can then be fulfilled so that they can continue to work clinically and contribute to the care of patients.[3]

Although the General Dental Council supports coach mentoring for the profession, it does not fund it or make it a prerequisite, and consequently some dentists choose to go through a disciplinary process alone. Most dentists, however, self-fund coach mentoring with some support from either their Local Dental Committees or previously Health Education England. Funding for these services has been reduced. For UK dentistry to flourish, this decision needs to be reversed. The coach mentors in our research recognised the excellent work being undertaken by the Dentists' Health Support Trust, the Practitioner Advice Support Scheme of the Local Dental Committees, Health Education England (funding ceased in 2022) and the BDA Benevolent Fund.

However, we come back to Shaun's conclusion that if UK dentistry is to thrive, dentists and those overseeing dentistry must nurture those practising it. As a profession, we need to be aspirational in our support for dentists by making coach mentoring available to all dentists who seek it.[4,5] A preventive approach is particularly important to nurture young members of the profession as they leave foundation training and become dental core trainees and associates.[5]

P. A. Gowers, C. Louca, C. Machuca Vargas, D. R. Radford, Portsmouth, UK

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Paediatric dentistry

Chairside synopsis for children

Sir, a recent Letter to the Editor of the *BDJ*[1] highlights that perhaps there is a time lag between antimicrobial prescribing guidelines being released and associated changes to practitioner prescribing practices.

I was pleased to see that the College of General Dentistry produced a chairside synopsis for antimicrobial prescribing for common conditions in dentistry.[2]

As a paediatric dentist who appreciates the benefit of prescribing the most appropriate antibiotic, at the correct dose, I was disappointed not to see a chairside synopsis for children.

Therefore, using the extensive information in the College of General Dentistry guideline[2] we have produced a chairside synopsis for children, which we hope will make it easier for practitioners to correctly prescribe antibacterial for our younger patients (Table 1).

D. Baldwin, London; A. Kelly, Plymouth, UK

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Table 1 Chairside synopsis for antimicrobial prescribing in dentistry for common conditions in children. Summarised guidance reproduced with permission from Antimicrobial Prescribing in Dentistry: Good Practice Guidelines developed by the College of General Dentistry and the Faculty of Dental Surgery of the Royal College of Surgeons of England, 2020

Condition	Summary of recommendations*	Where antimicrobial indicated*, for children: (all oral doses for up to 5 days)				See*
Acute periapical infection (dental abscess)	Drain abscess, remove infected pulp or extract tooth Antimicrobials as an adjunct to definitive treatment **ONLY if evidence of systemic spread or diffuse swelling** Metronidazole/clarithromycin to be used as 2nd choice antimicrobials. BUT can be used as first line treatment: ✓ for patients allergic to a penicillin ✓ for patients who have had a recent course of a penicillin Clindamycin/cephalosporins/ co-amoxiclav **ONLY at the direction of an oral/ medical microbiology or infectious diseases specialist**	**1st Choice Antimicrobial**	Age	Oral dose	increased, if necessary, in severe infections, up to	p13
		PHENOXYMETHYLPENICILLIN OR	1–5 years	125 mg QDS	12.5 mg/kg QDS	
			6–11 years	250 mg QDS	12.5 mg/kg QDS	
			12–17 years	500 mg QDS	1 g every 6 hours	
		AMOXICILLIN	1–4 years	250 mg TDS	30 mg/kg TDS	
			5–11 years	500 mg TDS	30 mg/kg TDS (max. 1 g)	
			12–17 years	500 mg TDS	1 g TDS	
		METRONIDAZOLE (2nd Choice antimicrobial) OR	1–2 years		50 mg TDS	
			3–6 years		100 mg BD	
			7–9 years		100 mg TDS	
			10–17 years		200–250 mg TDS	
		CLARITHROMYCIN (2nd Choice antimicrobial)	1 month–11 years (body-weight 12–19 kg)		125 mg BD	
			1 month–11 years (body-weight 20–29 kg)		187.5 mg BD	
			1 month–11 years (body-weight 30–40 kg)		250 mg BD	
			12–17 years: 250 mg BD		increasing to 500 mg BD in severe infections	
Pericoronitis	Debride and irrigate pericoronal space, and drain if localised abscess Antimicrobials as an adjunct to local measures **ONLY if evidence of systemic spread, severe swelling or trismus**	**METRONIDAZOLE** 10–17 years of age 200–250 mg orally three times a day for up to 5 days or **AMOXICILLIN** 12–17 years of age 500 mg orally three times a day for up to 5 days				p49
Necrotising periodontal disease	Debride under local anaesthetic and OHI Antimicrobials as an adjunct to local measures **ONLY if evidence of systemic involvement**					p35
Acute pulpitis	Provide definitive treatment of the cause, such as extirpation of the pulp or extraction for a tooth with irreversible pulpitis	Antimicrobial not indicated				p65
Dry socket	Irrigate with sterile solution to remove debris and consider placing a suitable dressing in the socket which may relieve symptoms					p39

*Practitioners should refer to Antimicrobial Prescribing in Dentistry: Good Practice Guidelines for full wordings: https://cgdent.uk/antimicrobial-prescribing-in-dentistry/