The National Association of Prison Dentistry website (http://www.napduk.org) has recently been expanded and is now a major resource for prison dental professionals. As well as providing information on upcoming events, it contains a member area with a comprehensive reference section including policy documents, academic articles and a members' forum.

Prisoners have ready access to legal services, and complaints can be frequent, time consuming and costly. There has been an increase in interest shown by specialist dental law firms who now actively advertise their services to patients in prison. Prisoners in HMP Wakefield successfully brought an action against the Wakefield District NHS Primary Care Trust in 2011 over dental services resulting in costs to the NHS of nearly £350,000.[4]

C. A. Yeung, Lanarkshire

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THE WORD FROM DOWN UNDER

Whole mouth health

Sir, dental caries is, in 2015, still a pressing public health matter in Great Britain,[1] as well as here in Australia and worldwide. I was an NHS dentist (1958–1980) and always very busy treating caries. In 1980 I returned to Australia, recommencing practice but retiring in 1991 until, in July 1996, our granddaughter was diagnosed with early decay in an upper anterior tooth. Angrily I committed myself to this mission: Prevent oral diseases in children.

In January 1997 I was appointed as District Dental Officer, East Arnhem Land, in the remote tropical Northern Territory (NT) of Australia. In early 2001, during a recording annual DMFT in a NT district school, for the third consecutive year I observed the 6-7-year-old classroom's mouths were caries free! The conversation I then had with their two teachers explained why. I was told that these pupils had been served breakfast before the first lesson. Then after squeezing toothpaste onto their toothbrushes they were told to 'go outside to the water troughs, brush your teeth and rinse...and rinse and rinse your brush under the tap'. The teachers implied by the first 'rinse' to rinse your mouth, but the children misinterpreted that statement and literally rinsed... and rinsed and rinsed the brush under the tap! Of course, what they had unknowingly left in their mouths were the active ingredients in the toothpaste! Serendipity had stepped-in to maintain their dental health!

The concept evolved over time and in 2007 I renamed the approach: 'treat your whole mouth'. Since then, finding that children respond very keenly to the notion of painting, it has become 'paint your mouth'. My experience shows that this really does dramatically reduce DMFT. Inspired by this I have produced a series of eBooks for not only children but also adults. These are designed to be educating, entertaining and interactive.[2] Special needs and vulnerable children would also greatly benefit from this simple yet cost-effective approach.[3]

G. Pettit, Adelaide

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Consent down under

Sir, I am Cardiff graduate (1999) practising in Australia since 2003 and, as with the authors of *Consent - a new era begins,*[1] I am also a dento-legal adviser for Dental Protection, but based in its Brisbane office. The opinion piece explored the recent Montgomery case and its possible impact on the approach to consent in the UK which has strong echoes of, and an almost identical description of a 'material risk', as the watershed Australian case of Rogers *v* Whitaker (RvW) roughly 25 years ago. As I also maintain clinical practice I have made the same 'journey' that UK colleagues may well be embarking upon in understanding and applying the 'particular patient' test.

In the immediate period following RvW there was concern in Australia that the pendulum had swung too far in terms of the level of expected understanding of each patient's needs, fears, hopes, concerns and expectations – even when meeting and treating patients for the first time. Predictably enough the judgement was seized upon by claimant law firms and allegations regarding a failure to warn quickly became a regular feature of medical/dental negligence claims, although in the years that followed, several important legal cases have qualified and softened the apparently open-ended expectations.

In Australia the regulatory guidance regarding consent was changed fundamentally by RvW but in contrast the GDC's guidance in the UK was in place long before Montgomery and in a sense the law has caught up with the profession. Many contemporary clinicians are already adopting a more patient-centred approach to consent in response to our consumerist culture and perhaps reflective of the current generation of practitioners for whom 'doctor knows best' was never the norm.

It is virtually impossible to extrapolate from the Australian experience to the UK as the medicolegal landscapes starkly contrast. Significant tort law reform took place in Australia in the wake of the paralysing medical indemnity crisis in the early 2000s which dramatically reduced medical (and dental) litigation in Australia almost overnight resulting in the current relatively benign litigation environment. In contrast, at almost exactly the same moment in time, the UK was moving in the opposite direction and the Woolf reforms were transforming the UK into a global hotspot for clinical negligence litigation, led by the 'no win – no fee' law firms.

The Montgomery ruling is best viewed as an opportunity, not a threat. Clinicians who try to engage and actively involve their patients in decisions have little to fear from Montgomery and will be largely unaffected. However, it may well be different for those clinicians who maintain a paternalistic approach, as we saw in Australia. If material risks are discussed, and (importantly) this fact is adequately recorded in the clinical notes, Montgomery need not open the floodgates for claims based wholly on a failure to warn of material risks, however excited the claimant law firms might become initially.

A. Weston, Brisbane, Australia

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