COMMENT

Letters to the editor

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Patient safety

Complication or never event?

Sir, we welcome the review of never events and serious events related to dentistry published in the *BDJ*[1] and support the promotion of a patient-safety culture, particularly in the field of oral surgery, through implementation of surgical safety checklists with the aim of reducing the risk of such events.[2]

We can all agree that we need to protect patients for avoidable harm; however, surgery is an inherently risky business – when do surgical complications become never events? A never event is a specific type of serious incident that must meet all of the following criteria: being wholly preventable; having the potential to cause serious patient harm or death; having occurred in the past and being easily recognisable and clearly definable.[3]

Renton and Sabbah state that 'unplanned retained or displaced tooth roots' constitute retention of foreign objects and, thus, a never event.[1] However, a 'foreign object' is defined as one that is subject to a formal counting/checking process except where the item is intentionally retained, or is known to be missing, and where further action to retrieve may cause more damage.[4] We submit that a retained or displaced root is not a foreign object and that such identifiable surgical risks should be discussed with patients as part of the informed consent process. Moreover, in order to maintain and enhance engagement with surgical safety processes, it is important that we do not cloud the distinction between surgical complications and never events.

A. Dargue, E. Fyfe

1. Renton T, Sabbah W. Review of never and serious events related to dentistry 2005-2014. *Br Dent J* 2016; **221:** 71–79.
2. Fyfe E C C, Fleming C. The WHO surgical safety checklist in a dental teaching hospital department of oral surgery - a model for implementation. *Oral Surg* 2016; **6:** 180–185.
3. NHS England. Revised Never Events Policy and Framework. 27 March 2015. Available at: https://www.england.nhs.uk/wp-content/uploads/2015/04/never-evnts-pol-framwrk-apr.pdf (accessed October 2016).
4. NHS England. Never Events List 2015-2016. Available at: https://www.england.nhs.uk/wp-content/uploads/2015/03/never-evnts-list-15-16.pdf (accessed October 2016).

Professor Tara Renton responds: We welcome the question, by Dargue and Fyfe, regarding whether 'unplanned retained or displaced tooth roots' should be classified as a 'never event' (NE) in our recent publication.[1] By strict definition of NEs, by the serious event policy and framework, we agree that 'unplanned retained or displaced tooth roots' are not categorised as NEs.[2,3] However, our never event analysis highlighted that these events had been incorrectly reported as NEs,[1] and there is a need to clarify notifications regarding the specific surgical complications of 'unplanned retained or displaced tooth roots'.

The intended vital root retention (coronectomy) as part of a treatment plan with the consent of a patient is considered safe practice. However, if a further surgical intervention is required to manage recurrent infection or erupting roots, this, by definition, is moderate patient harm and is a notifiable safety incident (NSI) as stipulated by the CQC definition.[4]

The inadvertent retention or displacement of a vital apex of a root left in situ *after an unintended partial extraction, with subsequent patient notification, with no further intervention required, would also be considered safe practice.*

However, based upon the CQC definition of moderate harm:

'Moderate ***increase in treatment*** *means unplanned return to surgery or a* ***readmission,*** *prolonged episode of care,* ***extra time in hospital*** *or as an outpatient,* ***cancelling of treatment*** *or* ***transfer*** *to another treatment area;'*

if a vital or non-vital unplanned retained or displaced tooth roots occurs, requires additional necessary intervention, this by definition, is moderate patient harm and is a notifiable safety incident (NSI) as stipulated by the by CQC definition.[4] In addition if either 'unplanned retained or displaced tooth roots' occurs and the patient is not informed, this is a matter of proberty, as outlined by GDC standards of Duty of Candour.[5]

In summary, we agree with A. Dargue and E. Fyfe, that in order to maintain and enhance engagement with surgical safety processes, it is important that the distinction between surgical complications, never events and notifiable safety incidents is not clouded. However, the understanding of notifiable events as distinct from never events, and the required reporting standards must be explicit.

1. Renton T, Sabbah W. Review of never and serious events related to dentistry 2005-2014. *Br Dent J* 2016; **221:** 71–79.
2. NHS England. Revised Never Events Policy and Framework. 27 March 2015. Available at: https://www.england.nhs.uk/wp-content/uploads/2015/04/never-evnts-pol-framwrk-apr.pdf (accessed October 2016).
3. NHS England. Never Events List 2015-2016. Available online at https://www.england.nhs.uk/wp-content/uploads/2015/03/never-evnts-list-15-16.pdf (accessed October 2016).
4. CQC statutory notifications. Guidance for registered providers and managers of Primary dental care. April 2015. Available online at https://www.cqc.org.uk/sites/default/files/20150331_100501_v6_00_guidance_on_statutory_notifications_ASC_%20IH_PDC_PA_Reg_Persons.pdf (accessed October 2016)
5. Being open and honest with patients when something goes wrong (GDC Duty of candour). Available online at http://www.gdc-uk.org/Dentalprofessionals/Standards/Documents/Being%20open%20and%20honest%20with%20patients%20when%20something%20goes%20wrong.pdf (accessed October 2016).

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Holistic care

Vulnerable in pregnancy

Sir, I am writing with regard to a recent case which has highlighted the opportunity for the dental team to be involved in true holistic patient care. In this scenario, helping to ensure that a pregnant woman was receiving appropriate antenatal care, thereby serving as a safety net for a vulnerable adult.

During my first week of vocational training, a woman in her early twenties presented with a florid pregnancy epulis; she was unable to eat and was eight months pregnant. A referral was made to the local oral surgery unit where the lesion was successfully excised within a week. Following the surgery, the surgeon enquired about the patient's pregnancy, which was met with a vague answer. Further investigation revealed that the patient had not accessed any antenatal care or even visited her GP – this raised concerns about her social circumstances, which unfortunately turned out to be valid. There exists a duty to safeguard vulnerable adults and children (and unborn babies).[1] This patient's lack of antenatal care alerted us to her social circumstances; failure to access appropriate medical care constitutes neglect.[2]

I feel GDPs are well-placed to enquire about a patient's pregnancy and the care they are receiving. Just as we routinely give smoking cessation advice to patients who smoke, it surely makes sense to ask about antenatal care in pregnant patients. Something as simple as 'have you been for your scan?' can flag up individuals who may belong to – previously undetected – complex social circumstances and then help to facilitate access to the appropriate social and medical services. Credit to the observant surgeon who identified the patient's absence from antenatal care; she has now been given access to both obstetric and social care.

L. Olsson, R. R. Welbury, Glasgow

1. General Dental Council. Standards for the dental team. 2013. Available online at http://www.gdc-uk.org/Dentalprofessionals/Standards/Documents/Standards%20for%20the%20Dental%20Team%20-%20Printer%20friendly,%20colour.pdf (accessed November 2016).
2. Lewney J, Boland B. Adult safeguarding; guidance for dental professionals. *Br Dent J* 2015; **219:** 287–291.

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Occupational health

A positive and proactive approach

Sir, I read with interest the article by Vijay and Ide[1] which highlights how the well-recognised issues with musculoskeletal disorders (MSDs) in dentists are also demonstrated in dental students.

As a practising dentist for over 20 years, I understand that dentistry is a uniquely challenging profession.

When I retrained as an osteopath in the 1990s, there was a clear understanding that good working habits should be instilled from the beginning of the course. These principles were emphasised by every member of staff from day one in order to reduce physical stress when treating patients and to reduce the risk of MSDs both in the short and in the long term.

Indeed 25% of the marks at every clinical technique assessment were allocated to the category of 'care of self'. This meant there was an inducement to keeping your own back, shoulders, wrists etc in the best possible position, rather than focussing solely on the end point of the clinical technique. I wonder if this concept could be applied to dental students?

However, the stresses involved in dentistry are not purely physical. Good posture cannot be the sole focus.

The modern approach to back pain in any population is to take a biopsychosocial approach, with attention paid to understanding and managing stress. This is essential in dentistry where the emotional demands are high. It is noted in the title of Myers' paper on stress and health in the general dental practitioner, 'It's difficult being a dentist'.[2]

Another important factor is physical conditioning. Evidence is accumulating about the positive benefits of exercise and physical activity on many aspects of health, including mental health.

The specific benefits of exercise in reducing back pain have been shown by many studies, including the one cited by Peros *et al.*[3] which showed that dental students who exercised more regularly had significantly less back pain.

In conclusion, may I suggest a positive, proactive and holistic approach is adopted with the emphasis on the health and wellbeing of the individual, from the early stages of dental school and continued throughout working life? The aim would be to help to enjoy long and fulfilling careers.

G. Gallacher, Bristol

1. Vijay S, Ide M.. Musculoskeletal neck and back pain in undergraduate dental students at a UK dental school – a cross-sectional study. *Br Dent J* 2016; **221:** 241–245.
2. Myers H L, Myers L B. 'It's difficult being a dentist': stress and health in the general dental practitioner. *Br Dent J* 2004; 197: 89–93.
3. Peros K, Vodanovic M, Mestrovic S, Rosin-Grget K, Valic M. Physical fitness course in the dental curriculum and prevention of low back pain. *J Dent Educ* 2011; **75:** 761–767.

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Law and ethics

Worrying attitudinal issue

Sir, I write with regards to the opinion piece by P. Singh, *Orthodontic allegations raised against registrants by the GDC*.[1]

Whilst it is to be applauded that such an article has been published to raise practitioners' awareness of this burgeoning field of investigation by the GDC, I am somewhat dismayed to read the emphasis that the writer P. Singh has placed on their role as 'Expert Witness for the GDC'.

The role of an expert witness is one of absolute impartiality and their role is to assist a court or disciplinary committee in exercising its duty. To therefore imply one is a witness for one side or another suggests bias towards the side one has received instruction from. Whilst I am sure this may be due to a lack of experience the writer may have in the field or expert witness work (as I notice they are newly appointed to the role and therefore this may be an innocent misunderstanding), it reveals a more worrying attitudinal issue that some expert witnesses appear to have, in that they are under the misunderstanding that they actually are an advocate for a side in a case and therefore their impartiality may be called into question. It may be that some have a poor understanding of their responsibilities as an expert witness unless they have taken further CPD in this field. They may also be therefore unaware of the potential for them to be litigated against for exhibiting bias if this is found to be the case. Expert bias can be displayed in many forms, not least the dogmatic adherence to 'Gold' or aspirational standards that leave many practitioners falling well below this level of measurement.

As an expert witness myself, and having taken instructions by the GDC amongst others, I am well aware of the pressures of instruction, and to remain purely impartial is, at times, a challenge. One must constantly question oneself as to whether any form of bias is being shown when acting in this role. One must always remember that the expert witness is not the final arbiter of the case, but their opinion may be fundamental in the decision made. However, given some of the allegations found in the GDC charge sheets in the past, this might not have necessarily been the case with some of the experts.

It is to be hoped that the GDC is seeking to address these issues with those expert witnesses who have failed to fully understand their responsibilities by no longer instructing them.

S. Thackeray BDS, PGDip (Law), CUBS Accredited Expert Witness, by email

1. Singh P. Orthodontic allegations raised against registrants by the General Dental Council. *Br Dent J* 2016; **221:** 291-294.

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