COMMENT

Letters to the editor

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Minimal intervention dentistry

Greatly worried

Sir, I was pondering after the *BDJ* issue on the topic of minimal intervention dentistry (MID) (Volume 223 issue 3, published 11 August 2017) (fantastic edition by the way). Can you explain to me: if MID is now the correct way to practise dentistry and if the NHS contract of UDAs does not permit the treating of patients in an MID way as there's no UDA value for this, are we all in breach of GDC guidelines for not practising dentistry to current opinion? This really does worry me greatly. The UDA system rewards the turbine and not MID so, if a case was presented to them, could the GDC strike a dentist off for not following current thinking due to sticking to their contract of outdated philosophy?

M. Wint, by email

Len D'Cruz, GDP and Dento-Legal Adviser, DPL replies: Thank you for your interest in the MI themed issue. The points you raise are very relevant and pertinent to how MI dentistry becomes more mainstream in the coming years. One of the reasons I became involved with Avi [Professor Avi Banerjee] in the first place was the recognition that the NHS pilots and now prototypes were the perfect test bed for these ideas, starting with the care pathway process and detailed oral health assessment that are required for every patient.

My own practice is part of the pilots/prototypes and the concepts of MI dentistry are very much part of this going forward, with risk assessments an integral part of delivering prevention, less intervention and behaviour change. It remains to be seen whether these laudable aims get translated finally into the substantive contract. The UDA system currently does allow for phasing of treatment and this is firmly established as a reasonable way of delivering care to high needs patients without being accused by NHS England of 'splitting' treatments. I hope it does not always have to be 'turbine' dentistry.

With regards to your point about the GDC, the Council expects clinicians to keep up to date and to follow guidance:

Standard 7.1

You must provide good quality care based on current evidence and authoritative guidance

7.1.1 You must find out about current evidence and best practice which affect your work, premises, equipment and business and follow them.

7.1.2 If you deviate from established practice and guidance, you should record the reasons why and be able to justify your decision.

With the BDJ *themed issue to add to the two series on MI dentistry previously published in the* BDJ *over the last few years, it is inevitable that this will become standard practice both in terms of the regulator as well as setting the standard in civil claims of clinical negligence.*

I hope this helps crystallise your views about the efficacy of the MI approach both in private as well as NHS dentistry although it will up to the CDO and NHS England to set the eventual direction of travel.

Dr Bhupinder Dawett, GDP replies to M. Wint: You raise really important concerns that a lot of GDPs I believe would be also be thinking about. I think there are three issues raised in your letter:

Point 1

You state that 'the NHS contract of UDAs does not permit the treating of patients in an MID way as there's no UDA value for this'.

If we take for example the MID stages:

Detection: To detect early lesions may be done in a practice with minimal extra time consumed. Look for example ICDAS,[1] the use of intra oral camera to record teeth (I agree that this may be an extra expense but so is a turbine, autoclave, etc … and probably at less cost … not to mention the intangible benefits eg patient communication, contemporaneous medicolegal records, etc. Also re detection radiographic guidelines, eg FGDP(UK) guidelines,[2] have been present for some time and set a reference that dental teams need to consider as part of routine care not just those with a MID focus.

Prevention: Again I agree with you that the UDA system is weighted towards restorative dentistry rather than prevention. Len describes (above) the prototypes and that hopefully these may start to change the focus. However that said, it is still incumbent on clinical professionals to provide preventive advice and interventions, eg the EBTK.[3] Again concerns have been raised that this is difficult at average UDA levels.[4]

Restoration: Here MID may actually be easier than traditional approaches – using biologically favourable approaches resulting in smaller cavity preps, etc.

Recall: Here the guidance from NICE is available to help dental teams and is risk-based. This risk-based recall is completely in line with the MID philosophy.

Point 2

You state that 'The UDA system rewards the turbine and not MID'.

I would agree with you that a UDA system with one UDA encompassing all prevention and three or more UDAs being rewarded for restorative care does appear to reward operative dentistry more. But remember MID also includes operative dentistry with a minimally invasive approach. Therefore in Band 2 for example cutting smaller holes does not reward one with less UDAs than cutting larger ones. More importantly this still includes a risk-based assessment and as Len so rightly says that phasing of care to high needs patients is a logical and sensible approach in helping a patient achieve and maintain oral health.

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Point 3

You ask, 'could the GDC strike a dentist off for not following current thinking due to sticking to their contract of outdated philosophy?'

I totally agree with Len's response here. The GDC will not as far as I am aware consider the UDA remuneration of a practice when looking at clinical probity in the care of a patient.

Standard 1.7 Put patients' interests before your own or those of any colleague, organisation or business.

As far as I am aware the GDS contract does not say anything about sticking to an outdated philosophy and we should not forget that current thinking is changing. Certainly the MID approach is being taught more in dental schools, so for new graduates (and certainly those on postgraduate courses like the AMID) there is no such thing as outdated philosophy; it is evolving evidence based care. Again Len's response is spot on and hopefully the DH will take on board findings from the prototypes for a substantive contract.

Standard 7.1.1 Find out about current best practice in the fields in which you work. Provide a good standard of care based on available up-to-date evidence and reliable guidance.

The use of DCPs, novel ways of remunerating dental staff, etc may well help practices to better implement an MID approach (some ideas are taught on the AMID programme).

However, we do need to look at some research that actually investigates the issues that practices face in implementing an MID care pathway for patients. This research needs to be practice-based so that its takes into consideration the views of all stakeholders including the dental team, commissioners, practice owners, etc. This is essential so that we can determine issues and the best ways to overcome these so that MID may be readily implemented at the coal face. From a personal point this is now firmly on the agenda with my research proposal, and those of others, being commissioned with the NIHR but others as well).

The other aspect to remember is that patients deserve to be involved in the clinical decision making of their care and as such options (including their pros and cons) need to be discussed with them. Here Len is totally correct that this and any deviation from accepted standards needs to be recorded.

Standard 1.1.1 You must discuss treatment options with patients and listen carefully to what they say. Give them the opportunity to have a discussion and to ask questions.

Standard 3.1.3 You should find out what your patients want to know as well as what you think they need to know. Things that patients might want to know include: options for treatment, the risks and the potential benefits.

1. Ormond C, Douglas G, Pitts N. The use of the International Caries Detection and Assessment System (ICDAS) in a National Health Service general dental practice as part of an oral health assessment. *Prim Dent Care* 2010; **17:** 153–159.
2. FGDP(UK). *Selection criteria for dental radiography.* 2013.
3. Department of Health/BASCD. *Delivering better oral health – An evidence-based toolkit for prevention.* 3rd edition. June 2014.
4. Page J, Weld J A, Kidd E A. Caries control in health service practice. *Br Dent J* 2010; **208:** 449–450.

Professor Avijit Banerjee, Guest editor of the BDJ MID Themed issue, sums up: I am grateful to my two colleagues for their full and comprehensive responses with which I fully concur. My only addition to both replies would be to emphasise that MI is considered ethical best practice and we wouldn't expect to receive less as patients ourselves. This is the critical point. As I mentioned in my editorial, a dentist doesn't become a dentist because of the system they work in but because they want to help and serve patients with the most appropriate care to assist them in maintaining their oral health. This is now the norm for undergraduate education.

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Dental notation

A case of the craftsman

Sir, I must take the opportunity to strongly disagree with M. J. Trenouth's comment about FDI Dental Notation.[1]

This system is quite clear to understand, easy to use, universal and does not demand any mental gymnastics whatsoever for sharp minds.

I do not believe the problem resides with the system but it is more a case of the craftsman.

J. M. R. Costa, Leyland

1. Trenouth M J. Dental notation: Mental gymnastics. *Br Dent J* 2017; **223:** 551.

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Erratum

Research Article *BDJ* 2016; **220:** 121-127

The following digital object identifier (DOI) number associated with this article was incorrect in the PDF version of the article in the original issue as published on the 12 February 2016. The correct DOI is 10.1038/sj.bdj.2016.94.
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