Oral cancer – CPD and the GDC

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Key points

Highlights the seriousness of a late or misdiagnosis of oral cancer for patients, the individual healthcare worker, the maintaining of standards, and the upholding of public confidence in the profession.

Demonstrates the importance of following the General Dental Council's guidance on professional standards and also national referral guidelines for suspicious oral lesions as these are the standards and guidelines by which individual registrants and their performance will be judged.

Suggests that the General Dental Council's requirements on continuing professional development, with regard to 'Oral Cancer: Early Detection', may be contributing to the reduction in complaints involving oral cancer being considered by the General Dental Council's Fitness to Practise processes.

Oral cancer is a horrible, disfiguring and potentially life-shortening disease. The impact of a late or misdiagnosis of oral cancer is evidently serious for patients, serious for the individual healthcare worker, serious for the maintaining of standards, and serious for the upholding of public confidence in the profession. This paper looks at the General Dental Council's expectations and the role of national guidelines with regard to the responsibility of the individual dental professional in identifying potentially serious oral mucosal abnormalities and timely onward referral of patients. The paper also considers the role of continuing professional development, required by the General Dental Council, in the performance of the dental profession in the correct handling of patients with suspected oral cancer. The numbers of cases before the General Dental Council over the past few years involving complaints of late or misdiagnosis of oral/mouth cancer are explored and reasons for the reduction suggested.

Introduction

Misdiagnosis or late diagnosis of oral cancer is a serious matter at so many levels. It is serious for patients, serious for the individual healthcare worker, serious for the maintaining of standards, and serious for the upholding of public confidence in the profession. Ensaldo-Carrasco *et al.* have recently developed an international consensus on 'never events' in primary care dentistry with 'failure to refer for oral cancer assessment after patient's lesions do not heal after two weeks of receiving treatment' achieving one of the highest scores for agreement among the experts surveyed.[1]

The General Dental Council (GDC) stated in 2013 that 'We require you to do CPD [Continuing Professional Development] because the GDC's purpose is to protect patients and the public. CPD helps to maintain public confidence in the dental register by showing that dental professionals are staying up to date. This is so you can give your patients the best possible treatment and make an effective contribution to dentistry in the UK'[2] and also, with regard to recommended topics for CPD, 'We make these recommendations because we believe regularly keeping up to date in these topics makes a contribution to patient safety.'[2]

This paper seeks to understand the GDC's view of CPD for the dental team and how CPD and wider guidance on oral cancer might impact patient safety with regard to this disfiguring and potentially life-shortening disease.

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Background

'My future and my past circle each other like salivating dogs' says the character Gemma Woodstock in *The dark lake*[3] – a sentiment that any dental healthcare professional investigated by their regulator, the General Dental Council (GDC), will recognise. However, in the context of a missed or late referral of a patient with oral cancer, the emotional turmoil of investigation by the GDC is intertwined with the painful professional realisation that a patient may have been significantly harmed to the point of life-changing surgery and other treatments, or even early death.

An example of a determination from a case before the GDC's Conduct Committee involving oral cancer in 2010 is as follows (with the names of the dentists removed):[4]

'...Patient A attended the practice between February and May 2007 because of an ulcer on her tongue. On 30 March 2007 you treated Patient A for the first time. On this occasion you noted an ulcer on her tongue and considered urgently referring Patient A to a specialist service. You declined to do so after consulting with (another dentist) who did not carry out any detailed examination. You did not make any detailed record of your examination of this occasion nor did you take any social history which would have been relevant in her case.

On 16 April 2007 you saw Patient A for the second time as an emergency.

Despite the fact that the ulcer on Patient A's tongue was still present and had been present for longer than the three weeks recommended for urgent referral under the National Institute for Health and Clinical Excellence, 2005 guidelines, you nevertheless were misguided by the false reassurance of the appearance of the ulcer and the fact Patient A looked better. You again failed to refer and made inadequate notes of this consultation. You also failed to recall the patient for a review and discharged the patient back to the care of (another dentist) and in a perfunctory manner.

Although your case involved only one patient, the failings occurred on two consultations and were numerous. The effect of your failings was that Patient A was deprived of an urgent referral to a specialist service. Patient A died following complications after surgical treatment for oral cancer. Expert opinion given to the Committee in evidence indicated that the outcome would have been the same in any event. Nevertheless, Patient A was entitled to proper care which would have improved the quality of her life in those last months. Your failure to refer prevented Patient A receiving an earlier diagnosis of an oral cancer.

Your failings breached the GDC's ethical guidance, Standards for Dental Professionals, May 2005, namely [these are listed as 1.3, 1.4, 2.4, 4.3 and 5.3].The Committee has considered carefully whether your identified failings amounted to mere negligence albeit, on two separate occasions, arising out of clinical misjudgement. However, both individually and cumulatively they were serious failings which in the view of the Committee fell significantly short of acceptable standards and therefore amount to misconduct.'

Two things should be noted from this determination: firstly, where a complaint is made to the GDC, dentists and dental care professionals (DCPs) are assessed against the GDC's ethical guidance in place at the time of the alleged incidents (these may be different from those in place at the time of any hearing) and, secondly, that dentists and dental care professionals are held accountable to the national guidance in place at the time of the alleged incidents – in this case the NICE Guidelines from 2005 – and such national guidance may be specific to each devolved administration for example, the head and neck cancer referral guidelines (and, indeed, other guidelines) may differ in Scotland from England.

What is expected of the profession?

From the earliest days of CPD becoming a legal requirement, the GDC has highlighted areas of practise that are 'highly recommended', including medical emergencies, disinfection & decontamination, radiography & radiation protection. A further tier of 'recommended' areas for CPD includes oral cancer: early detection and this has persisted into the new system of enhanced CPD, introduced by the GDC for dentists and DCPs in 2018.[5]

In October 2013, a joint statement on mouth cancer diagnosis and prevention was issued by the British Society for Oral Medicine (BSOM) and Cancer Research UK (CRUK) with the Chief Dental Officers of England, Wales, Northern Ireland and Scotland; the Royal Colleges' Dental Faculty Deans in England, Edinburgh and Glasgow; the British Dental Association (BDA); the British Dental Health Foundation (BDHF); the British Society for Oral and Maxillofacial Pathology (BSOMP), the British Association of Oral & Maxillofacial Surgeons (BAOMS), the British Association of Oral Surgeons (BAOS), and the Association of British Academic Oral & Maxillofacial Surgeons (ABAOMS).[6]

This joint statement, from organisations representing many clinicians involved with diagnosing and treating patients with mouth cancer, asked that strategies be set in place to: (1) encourage better public awareness and knowledge of mouth cancer; (2) enhance prevention of mouth cancer; and (3) ensure better professional awareness and knowledge of mouth cancer.

The joint statement went on to state:

'(a) it is important that high uptake of good-quality Continuing Professional Development programmes is encouraged;

(b) 'Oral Cancer: Early detection' is an important topic of the General Dental Council (GDC) guidance for Continuing Professional Development (CPD) for Dental Professionals;

(c) the GDC should also consider making this a "highly recommended" CPD subject.'[6]

The GDC has chosen not to implement the requested change of status from 'recommended' to 'highly recommended' and, while the GDC has set in place quality assurance 'checks' for use at local level for any CPD activity to be claimed as verifiable (historically) or recordable under the enhanced CPD system, it is not clear how the quality of CPD programmes (or those who deliver them) is reliably assured nationally. But, perhaps more importantly, is there any evidence to suggest that adhering slavishly to a system of CPD makes any difference to standards within the dental profession and, in particular, does it make it more likely that patients will be protected from a misdiagnosis or late diagnosis of oral cancer? Further, is there any published qualitative research from work with colleagues within the dental profession who have been involved in cases of misdiagnosis or late diagnosis of oral cancer as to why such issues arose? It must surely be too simplistic to consider that such colleagues simply did not attend enough CPD courses or CPD courses of sufficient calibre? Here is an area worthy of further research.

Box 1 Different terminologies used for 'oral cancer'[7,8]

Cancer of the tongue and oral cavity and pharynx (Møller 1989)
Cancer of the oral cavity/oropharynx (Merletti *et al.* 1989)
Tongue and mouth cancer (Franceschi *et al.* 1990)
Malignant oral tumours (Östman *et al.* 1995)
Mouth cancer (Moore *et al.* 2000)
Oral cavity and pharynx cancer (Canto and Devesa 2002)
Cancer of the oral cavity (Carvalho *et al.* 2004)
Oral and pharyngeal cancer (Tarvainen *et al.* 2004)
Intraoral cancer (Chandran *et al.* 2005)
Oral cavity and oropharyngeal cancers (Gillison 2007)
Oral cavity and pharynx-throat cancer (Rodu and Cole 2007)
Cancer of mouth and pharynx (Tarvainen *et al.* 2008)
Oral and oropharyngeal cancer (Warnakulasuriya 2009)
Cancer of oral cavity and pharynx (Goldstein *et al.* 2010)
Oral cancer (Zini *et al.* 2010)
Oral cavity cancer (de Camargo Cancela *et al.* 2010)
Oral malignant tumours (Rojas Alcayaga *et al.* 2010)

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Box 2 Urgent suspicion of cancer referral[12]

Head and neck cance

- Persistent unexplained head and neck lumps >3 weeks
- Ulceration or unexplained swelling of the oral mucosa persisting for >3 weeks
- All red or mixed red and white patches of the oral mucosa persisting for >3 weeks
- Persistent hoarseness lasting for >3 weeks (request a chest x-ray at the same time)
- Dysphagia or odynophagia (pain on swallowing) lasting for >3 weeks
- Persistent pain in the throat lasting for >3 weeks

Box 3 Suspected cancer guidelines[13]

1.8.2 Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for oral cancer in people with either:

- unexplained ulceration in the oral cavity lasting for more than 3 weeks or
- a persistent and unexplained lump in the neck.

1.8.3 Consider an urgent referral (for an appointment within 2 weeks) for assessment for possible oral cancer by a dentist in people who have either:

- a lump on the lip or in the oral cavity or
- a red or red and white patch in the oral cavity consistent with erythroplakia or erythroleukoplakia.

1.8.4 Consider a suspected cancer pathway referral by the dentist (for an appointment within 2 weeks) for oral cancer in people when assessed by a dentist as having either:

- a lump on the lip or in the oral cavity consistent with oral cancer or
- a red or red and white patch in the oral cavity consistent with erythroplakia or erythroleukoplakia.

Definitions are important

As will be evident from the foregoing, in the world of professional and regulatory law, guidelines and definitions are important. As the GDC expects its registrants to be updated regularly on the topic of 'oral cancer: early detection',[5] it would seem sensible to investigate the definition of 'oral cancer'.

Tapia and Goldberg[7] reviewed the various terminologies used for 'oral cancer' and identified there was a distinct lack of consensus. This is shown in Box 1.[8] Accordingly, there have been attempts to clarify the definition, emphasising anatomical boundaries to the mouth/oral cavity and oropharynx but also attempting definition on risk/aetiological factors with the view that oropharyngeal cancer has human papilloma virus (HPV) much more commonly implicated than in oral cavity/mouth cancer.[9]

The major 'battlefield sites' are the lingual tonsil, soft palate, uvula and base of tongue with a number of significant epidemiological studies (for example, INHANCE)[10] opting to include these sites in the oropharynx – and thus sites of oropharyngeal, rather than oral cavity, cancer. However, consensus is not evident in the literature and this is not helpful for members of the dental team faced with potential concerns over professional responsibilities for detecting cancer in the mouths of patients. As will be evident from the list of 'battlefield sites', despite these being included in the oropharynx, they are likely to be obvious sites to examine in a routine dental setting with the notable exception of the base of tongue. Perhaps it would be helpful and practical, therefore, to acknowledge a more generalised definition of 'oral cancer' which combines both oral cavity cancer and oropharyngeal cancer, while appreciating that lesions at the base of tongue may well escape notice from even the most observant and fastidious practitioner without specialised equipment – and this would be beyond the expectation of the general dental practitioner.

Examination for signs is one thing, but what about symptoms? Barnes (2005) noted that the symptoms of oral and oropharyngeal cancer may be complex and diverse, including pain in the throat, neck, tongue, palate and ear and that there is a need for a 'high index of clinical suspicion, particularly in high risk patients.'[11] Although the average general dental practitioner might not reasonably be expected to visualise and identify all oropharyngeal tumours, particularly at the base of tongue, perhaps consideration should now be given to enhanced education (at both undergraduate and postgraduate levels) around 'symptom clusters' which might alert the practitioner to the need for referral to secondary care for further investigation? It seems sensible that this should be included in programmes for oral cancer enhanced CPD going forward.

Guidance on referral

It is essential to identify and understand which guidelines are in place for managing patients with various conditions (suspected and diagnosed) within the modern health-care setting – and, importantly, to be part of a professional organisation, such as the British Dental Association (BDA) or Faculty of General Dental Practice (FGDP) which will inform membership when such guidance is about to change, or has changed.

In Scotland, the Scottish Referral Guidelines for suspected cancer apply and relate to head and neck cancer generally but with specific findings relevant to the dental team (Box 2).[12]

What could be improved within the Scottish Guidance? Practitioners are 'trapped' into referring, for example, a patient with a major aphthous ulcer or a combination of reticular and atrophic lichen planus. Both these conditions are discrete, non-malignant diagnoses and, as such, could be referred outside the 'urgent' pathway.

In England and Wales, the NICE Guideline, NG12, *Suspected Cancer: Recognition and Referral* applies and deals specifically with oral cancer (Box 3).[13]

Identifying the pivotal role of the dentist in patient assessment is to be applauded but what could be improved within the NICE Guidance? It is helpful that the term 'unexplained' is used with regard to ulceration as this removes the need to refer patients with, say, aphthous ulceration. However, the chronicity of the lesion (three weeks) is lost to other terms within the list subsequent to "ulceration" with no indication of how long one should observe a neck lump or white/red patch before referring. Lumps in lips are likely to be mucocoeles and even if they are minor salivary gland neoplasms, their behaviour will be quite different from an oral squamous cell carcinoma within the mouth, but it is good that dentists are being asked to see patients as 'experts in the mouth' before referring on if required. The guidance makes no attempt at risk stratification by site for white/red patches within the mouth – floor of mouth, ventral and lateral surfaces of tongue cause more concerns than other sites, albeit that all will require assessment.

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Table 1 Complaints relating to a failure to diagnose (or lateness to diagnose) oral cancer/mouth cancer

	2012	2013	2014	2015	2016	2017
Total number of cases	2	4	7	2	5	0
Conditions and additional prosecution case raised on hold*	0	1	0	1	0	0
Reprimand	0	0	1	0	0	0
Conditions issued**	0	0	3	0	0	0
Interim order committee conditions issued	0	0	0	0	1	0
Registrant issued with advice	1	1	1	0	0	0
Professional conduct committee stage – still in progress	0	0	0	1	2	0
Case examiner stage – still in progress	0	0	0	0	1	0
Case closed – no further action	1	2	2	0	1	0

*Both cases are related to the same registrant; **Two of the three cases relate to the same registrant

In addition to the guidance which pertains directly to oral cancer, dentists and DCPs would be advised to read the generic standards guidance from the GDC – *Standards for the Dental Team*[14] – on a very regular basis. This document makes the expectations of the GDC very clear:

'The standards set out what you must do. If you do not meet these standards, you may be removed from our register and not be able to work as a dental professional.

The guidance is there to help you to meet the standards. You are expected to follow the guidance, to use your professional judgement, demonstrate insight at all times and be able to justify any decision that is not in line with the guidance. Serious or persistent failure to follow the guidance could see you removed from our register and not able to work as a dental professional.'[14]

In a world of robust professional regulation and high patient expectation, as well as for the simple desire to 'get it right' for patients, it is important that we know, understand and implement the standards and the guidelines that apply in all circumstances. Where deviation from a local or national guideline is evident, the practitioner responsible for the deviation will be required to justify his/her actions.

However, it is very important to appreciate that dentists and DCPs, with regard to national guidelines on referring patients with putative oral cancer, are simply required to consider the *possibility* of oral cancer in a set number of circumstances and not necessarily to diagnose oral cancer. Similarly, the national guidelines ask that a practitioner recognises a persistent abnormality (oral mucosa or lymph nodes) and takes the appropriate action with regard to referral – again, there is no requirement to establish the diagnosis of oral cancer before referral, simply to note that a particular abnormality is present, thus raising the suspicion of oral cancer. Thus the question, 'I don't know if this is cancer or not' is irrelevant – if the mucosal or lymph node abnormality is present persistently then make the referral!

Are we as a profession getting better or worse with regard to oral cancer?

This is a very difficult question to answer as there are many variables to be considered, including how the GDC may have changed how they handle complaints in any time-frame analysed. However, one of the dental defence organisations (DDU) reported in 2013 that it had dealt with 63 cases of oral cancer in the five years, 2008–2012.[15] Of these, 53 cases alleged 'the dental professional failed to check the patient for oral cancer during their examination, didn't diagnose a suspicious lesion that was present, or there was a delay in referring to a specialist.'[15]

In at least four cases, the patient died. Of the 63 cases, 31 cases were reported to the GDC with full investigations in six. Thus, in this five-year period, which terminated in the year that 'oral cancer: early detection' was introduced by the GDC (that is, 2012), one dental defence organisation reported 31 cases being reported to the GDC – and we can safely assume that the other defence organisations were dealing with similar equivalent numbers.

A Freedom of Information request to the GDC (dated 29 August 2017) revealed that the GDC dealt with 18 cases of failure to diagnose or lateness to diagnose oral cancer in the five years subsequent to 2012 (2013–2017) (Table 1).

While accepting that the data for 2017 are incomplete, this appears to demonstrate a remarkable turn-around in the number of cases being handled by the GDC. It would be somewhat simplistic to suggest that this transformation in the profession was all down to CPD, but it must be accepted that CPD is at least implicated in the improvement.

So, while the GDC have not moved 'oral cancer: early detection' into the 'highly recommended' category, we must commend the Council for keeping the topic to the forefront of the profession's thinking in the development of Enhanced CPD as a recommended topic. The impact of this requires to be formally assessed prospectively from 2018.

Conclusions

There are several lessons to be learned from reflecting on the issues raised in this article.

As a profession, we must ensure that we are implementing local and national guidelines with regard to identifying significant and lasting oral mucosal conditions and unexplained lymph node enlargement – you might just be looking at oral cancer in the next patient you see! National guidelines for oral cancer are not attempting to make us experts in diagnosing oral cancer – that would be very difficult given the small numbers seen by the average dentist in a practising lifetime. We are, however, expected to recognise the abnormalities described in the guidelines and to take appropriate action in an appropriate time-frame.

However, if and when the guidelines we are following could be improved upon, let's not simply soldier on under the burden of defective guidelines, let's instead ensure that as a profession we respond to any consultation process and invoke the resultant, necessary changes.

If there is a Harold Shipman-equivalent in UK dentistry, I have yet to meet that individual. Further, none of the practitioners I have met who failed to diagnose a patient with oral cancer (or did so late) have found it anything other than a devastating experience, living with daily, often incapacitating guilt for the remainder of their professional lives. We need to find out why these relatively infrequent mishaps occur with qualitative research conducted on behalf of the GDC and dental defence organisations. Although, if the GDC's FOI oral cancer reported cases data for 2012–2017 persist over the next five-year period, it may be that the dental profession will be seeing the misdiagnosis or late diagnosis of oral cancer as a thing of the past. Let's stay vigilant but also ensure that further data reporting by the GDC occurs over time.

Too many of the patients reported by the DDU in their 2013 report in *Dentistry*[15] were clearly unaware that their dentist was examining them for oral cancer. This could never be the case in medicine with obvious examinations for cervical cancer or breast cancer. So, let's tell our patients at each and every check-up and at each and every visit that we are examining them for oral cancer and other mucosal diseases. Educating the public is an important forward task.

Oral cancer is a dreadful disease and the dental profession must not shirk its responsibilities towards effective, early referral and diagnosis. However, we must also reflect on our other responsibilities in that oral cancer may well be a largely preventable disease. Stephen Hancocks said in his *BDJ* editorial on 12 October 2013: 'as a profession we can and should exert ourselves more effectively in public health circles which in turn requires us to get more political and prepare ourselves for the future with the appropriate skills, knowledge and survival techniques.'[16]

That means that we should be dealing diligently with the aspects that impact oral cancer:

1. Dealing well with potentially malignant disorders such as oral lichen planus
2. Nutrition in prevention
3. Risk stratification for patients, particularly in regard to deprivation
4. Ensuring that 'at risk' groups have optimal review periods established
5. Tobacco-cessation optimised
6. Alcohol-cessation optimised
7. Ensuring that undergraduate and postgraduate education deals well with matters of ethnicity, culture and habits where these might increase the likelihood of oral cancer (for example, using betel)
8. Sexual health, with particular regard to HPV.

And so, while CPD to date has focused on 'oral cancer: early detection', there is so much more to explore and we now need to ensure that all aspects of oral cancer, in particular where the impact of prevention might be readily observed, are covered in undergraduate and postgraduate education to the highest possible standard.

Declaration of Interests
Professor Gibson sat on the GDC's Fitness to Practice Panel for ten years and was previously Chairman of Dental Protection Ltd and a board member of the Medical Protection Society. He is a member of the Medical & Dental Defence Union of Scotland.

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1. Ensaldo-Carrasco E, Carson-Stevens A, Cresswell K, Bedi R, Sheikh A. Developing agreement on never events in primary care dentistry: an international eDelphi study. *Br Dent J* 2018; **224:** 733–740.
2. General Dental Council. Continuing Professional Development for Dental Professionals (booklet), effective 30 September 2013.
3. Bailey S. *The Dark Lake*. Corvus, 2017.
4. General Dental Council.Determination of the Professional Conduct Committee from 25 November 2010 (accessed December 2010).
5. General Dental Council Recommended CPD topics. Available at https://www.gdc-uk.org/professionals/cpd/cpd-topics (accessed May 2018).
6. Joint statement from the British Society for Oral Medicine (BSOM) and Cancer Research UK (CRUK); Jessica Kirby (CRUK) and Crispian Scully (BSOM); 21 October 2013.
7. Tapia J L, Goldberg L J. The challenges of defining oral cancer: Analysis of an ontological approach. *Head Neck Pathol* 2011; **5:** 376–384.
8. Purkayastha M. Investigations into opportunities for early detection of oral cancer University of Glasgow, PhD thesis, 2018.
9. Hübbers C U, Akgül B. HPV and cancer of the oral cavity. *Virulence* 2015; **6:** 244–248.
10. INHANCE. International Head and Neck Cancer Epidemiology Consortium. Available at http://www.inhance.utah.edu/ (accessed: April 2018).
11. Barnes L (ed.). *Pathology and genetics of head and neck tumours*, IARC, 2005.
12. Health Improvement Scotland. Scottish Referral Guidelines for Suspected Cancer. NHS Scotland, 2015.
13. National Institute for Health and Care Excellence (NICE). Suspected Cancer: Recognition and Referral, NG12. 2015; updated July 2017.
14. General Dental Council. Standards for the Dental Team. 2013. Available at https://standards.gdc-uk.org/ (accessed October 2018).
15. Editorial, Dentistry, 21 November 2013. *Dentistry* 2013.
16. Hancocks S. Do we really care about caries? *Br Dent J* 2013; **215:** 313.