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# BDJ Student

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# BDJ Student

the British Dental Association's official magazine for students and first year graduates

WINTER 2015


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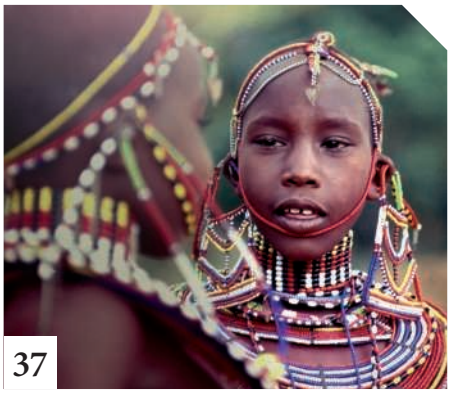

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# KNOWING YOUR NEXT MOVE...

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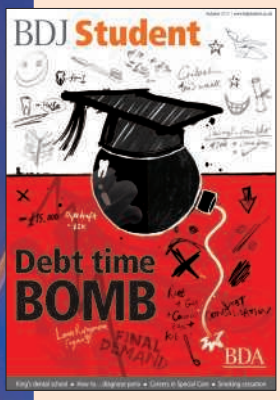
# EDITORIAL

## Julie Ferry, *BDJ Student* editor

## Bex Stockton, *BDJ Student*, student editor

Welcome back to *BDJ Student*. This is the second issue of our brand new magazine and we're excited to bring you more entertaining and informative articles to see you through the rest of Winter. First, though, the team would like to say a big thank you for all your feedback about our launch issue. We were thrilled to hear how much you enjoyed it, with many of you commenting on how *BDJ Student* reflects your needs and is preparing you for your future career. That's great to hear and please keep the comments coming - we love to know what is working (and what isn't). After all, it's your magazine and we want to get the tone and content just right. Also, I have been overwhelmed with offers of contributions to the magazine. It's wonderful to know so many of you want to be involved and that you have some great ideas. Please bear with us if it takes a while to respond.





As you might expect this issue is bursting with news, features and clinical articles, designed to keep you up to date and inspired. We also have devoted quite a lot of time to reporting on the political changes that are going on in the profession. These are really important because they shape the profession in which you will soon be practising, so it's vital you stay informed and get involved. This stuff *really* matters, even though it can seem a little removed from where you are now. To keep up to date, check out the Upfront section and our feature on the DFT-pay review on page 16.

For career inspiration, we have spoken to a paediatric consultant who tells us how she got to the top of her field (page 21) and bring you the first part of a column written for us by an SHO, so you can get an idea of what life is really like on the front line (page 23). For those of you who like to see how it's done at other dental schools, take a look at the views of both a staff member and a student at Manchester dental school (page 10). Hopefully that will keep you busy until Spring. See you then! **Julie Ferry** ■

Hello and welcome to our second issue of *BDJ Student*. I hope you've all had a relaxing Christmas break, especially those of you with looming coursework deadlines or January exams; I know the feeling! I'm Bex, your proud student editor, and I'm a fourth-year dental student.

I congratulate you for becoming a BDA student member. It's not just about the textbook discounts and the magazines. By becoming a member you have joined a community and trade union that fights for the future of our profession. As the last issue went to print, the BDA was fighting on our behalf to oppose the £2000 pay cut for foundation year dentists, which was proposed by the Department of Health. After a campaign, which included the lobbying of politicians and a high- profile petition (signed by many students), we were victorious and the plans were shelved. You can read more about the campaign on page 16.

Over the past few months, the BDA has been embroiled in legal proceedings against the General Dental Council (GDC), which has proposed a compulsory increase in the Annual Retention Fee (ARF). As *BDJ Student* went to press the verdict from a judicial review on the issue was imminent, turn to page 8 to find out more. With your support, you have personally helped these and more campaigns gain the attention they deserve. Nice one!

This year a couple of friends from my course at the University of Manchester have been brave enough to squeeze an intercalation year into their BDS degree. On page 12 I talked to some of them about their motivations and asked why so few of us choose not to follow suit. From my discussions with students and the Chair of the Committee for Postgraduate Dental Deans (COPDEND), as well as several dental school tutors, I found that, although the intercalated is incredibly demanding, it is balanced with a distinct competitive advantage for careers in academic and specialty dentistry, as well as reaping personal rewards such as new friends and experiences. Yet fewer than 20 of us graduated with an intercalated degree last year. It seems most of us think five years at university is enough, and I'm inclined to agree!

Looking ahead to March, there's not long to go now until the BDSA conference in London. I'm still on the waiting-list for a ticket, but fingers crossed! Enjoy your magazine, and best wishes for the 2015.

**Bex Stockton** ■

# BRITISH DENTAL CONFERENCE AND EXHIBITION 2015

## KICK-START YOUR ENTRY INTO DENTISTRY

The cliché is that the best things in life are free. And while the price of an Aston Martin or a Chanel handbag would certainly set you back, as a BDA Student member you won't have to pay a penny for this year's British Dental Conference and Exhibition.

Returning to the Manchester Central Convention Complex from 7-9 May, the event will feature leading names in clinical and cosmetic dentistry, live demonstrations, a buzzing exhibition, and seminars covering career development and regulation.

Our star clinical experts include Daniel Wismeijer, Professor and Head of Department of Oral Implantology and Aesthetic Dentistry, Academic Centre for Dentistry Amsterdam (ACDA); Basil Mizrahi, an Honorary Clinical Lecturer at the UCL Eastman Dental Institute, and Diplomate of the American Board of Prosthodontics; Francesco Mannocci, Professor of Endontology at King's College London Dental Institute; Chris Tredwin, Professor of Restorative Dentistry and Head of Peninsula Dental School; Jason Smithson, Private Practitioner and expert in restorative dentistry, Cornwall; Richard Cure, Head of Dentistry Studies and Clinical Director of Orthodontics at the University of Warwick; and Ian Dunn, Specialist Periodontist, Liverpool and Undergraduate Teaching Lead in Periodontics at Liverpool University.

The British Academy of Cosmetic Dentistry (BACD) mini-series will also be returning with a variety of sessions of interest to anyone looking to expand their knowledge of cosmetic dentistry alongside popular features including the A-dec and UCL Eastman Demonstration Theatre and the Exhibition Hall's Innovation Zone.

Business- and career-focused seminars and workshops are another programme highlight. Dental students will not want to miss ***The future for young dentists*** panel session hosted by the BDA's Young Dentists Committee. Chair of the BDA Principal Executive Committee, Mick Armstrong, has confirmed his participation on the panel. This session will discuss challenges and opportunities facing young dentists, the latest research on employment and earnings and tips on how to stand out from the crowd when applying for jobs. In other sessions Nick Lane, a Wakefield GDP, will explore the merits of a career in general practice, discuss how a postgraduate qualification can help, and look at the role the FGDP can play in shaping your career while James Goldman, head of the BDA's General Practice team, will also lead a panel session which will divulge how to stand out from the crowd when applying for a position as an associate.

> 'This session will discuss challenges and opportunities facing young dentists, the latest research on employment and earnings and tips on how to stand out from the crowd when applying for jobs.'

Booking for the event is now open. A three-day conference pass is FREE for BDA student members and significantly reduced for student non-members and Foundation Dentists.

Prospective delegates can register online at www.bda.org/conference or by calling 0870 166 6625. Students considering joining the BDA can find details at www.bda.org/join

*Please note!*
*The Government has announced that a UK general election will take place on Thursday 7 May 2015. If you are planning to attend the event on this day and wish to vote in the election you will need to apply for a postal vote if you cannot attend your local polling stations.*

**FREE FOR BDA STUDENT MEMBERS**

BLOG IT

This issue's hot topic from BDA Connect, bdaconnect.bda.org.

### Elective funding for dental students

*Olivia Johnson King, a Kings dental student and Student Trustee, gives the low-down on bursaries of up to £1000 available for dental electives.*

Are you a dental student planning an elective research project abroad and in need of a bursary? If so, the British Medical and Dental Students' Trust (BMDST) could help.

The BMDST is a charity which provides travel scholarships to medical and dental students going abroad for their electives. The trust provides grants of £500 to £1000 to applicants who satisfy the awards criteria.

The Trustees at the BMDST are looking for a well presented application of an elective attachment that is based on a research project. The research projects are often small, designed by and for the student, but also may be participation in an continuing larger research project.

#### How to apply?

The formal application form can be found on the BMDST website Your application should include the presentation of the proposed project:

- Introduction: Background to the proposed project. What interests you?
- Aims: What it is you wish to explore? State your objectives.
- Methodology: How do you intend to collect the information?
- Analysis: How do you intend to analyse the results and present them?
- Benefit and use of data: Both to yourself and for the unit in which you carried it out.
- Application: Identify possible application in clinical practice.

## Required documents

You will need a letter or email confirming your elective from own dental school. You will also need you host institutions recommendation from tutor or supervisor at your dental school.

***Incomplete or failure to send required documentation will result in the application being rejected. All applications are scrutinised by a panel of Trustees which includes student Trustees.***

## When to apply?

- Elective period April to September 2015 – apply by 31st January 2015
- Elective period October 2015 to March 2016 – apply by 31st July 2015

For more information please see the BMDST Website

Good luck with your application!

# CLIMBING KILIMANJARO






When a group of students decided to climb Mount Kilimanjaro for charity, they didn't realise what they were taking on. Here, Arjun Krishan Goswami from Bristol Dental School, explains the challenges they faced and why he chose MIND, as his charity

"I decided to climb Mount Kilimanjaro in July 2014 for the mental health charity MIND. It involved me having to trek up the Machame route of the mountain for five days and then trek down via the Mweka route for two days.

We were a group of three students climbing for different charities plus two guides, Michael and Justin, who were the most valuable addition to our group, helping us to face the variety of adverse weather and environmental conditions to reach the summit.

We started off walking through humid rainforest conditions, where the vegetation was rife and mysterious. We then continued onto a moorland terrain, that was drier and rockier and then into desert conditions, where the land was baron, dry and extremely hot in the sunlight. We finally reached base camp and were woken at midnight to climb to the peak, so we could catch the sunrise from the top. It was pitch black when we started the final ascent and it took us eight hours in arctic conditions to climb to the peak, which was by far the most physically and mentally demanding aspect of the whole trek. We watched the sunrise from Stella Point, which is the outer rim of the highest crater on Kilimanjaro: it was like the opening scene from the *Lion King*. We continued for another hour walking past the most beautiful glaciers and the ash pit of the dormant volcano to finally reach the Uhuru peak, 5895m above sea level. The emotion of reaching the top after five days was overwhelming and we all started to tear up, as we had finally reached our goal. We stayed at the summit for half an hour before having to trek downwards through gravel and rocky terrain due to the high altitude.

I chose to raise money for the mental health charity MIND because it was very personal to me. My father passed away suddenly in 2011, just three weeks after his 57th birthday. He had suffered from depression and addiction and had not received enough help at the right time, and I feel that if he had, he may still be with us today.

This trek was also in memory of my paternal grandparents. My grandfather suffered from early Alzheimer's and my grandmother had dealt with mental health problems at a younger age. As she was born in Tanzania it was just extremely fitting to carry out this challenge in the memory of all three of them.

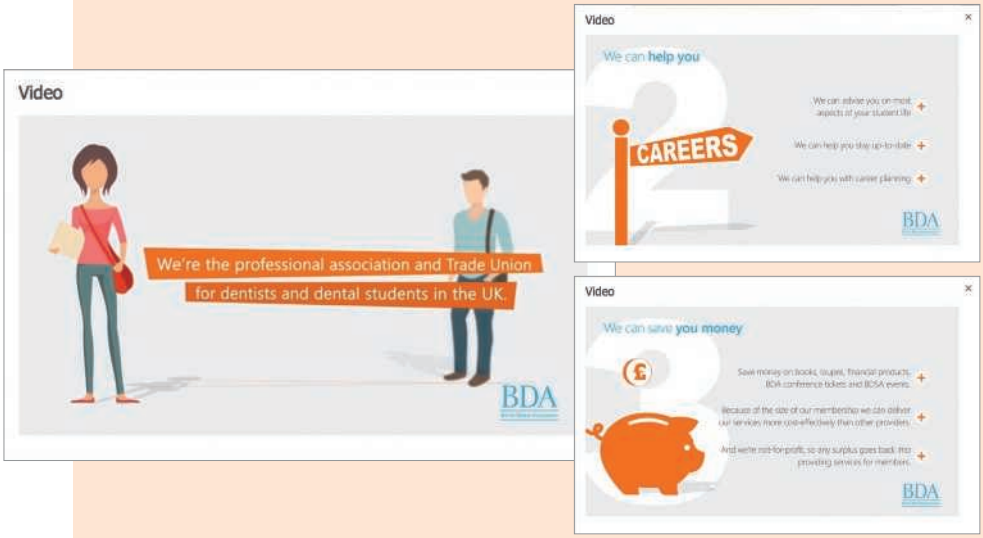
I ended up raising £3325 (not including gift aid) for MIND, so that there is funding to try and help people with mental health problems in future."

http://uk.virginmoneygiving.com/ArjunGoswami

**Arjun Goswami**

## CHECK OUT OUR NEW FILM

Who are the BDA and what do we do for you? Find out in our new short film at www.bda.org/studentjoin










REVIEWS: APP

## *iStuDent Lite*


Exams. They are probably something all dental students have in common and unfortunately we have a glorious five years of them! There are a number of revision books out there to give you a helping hand. However, have you ever stumbled across a dental revision app? Well I hadn't until *iStuDent Lite*. This bank of dental revision questions has *Conservative Dentistry* as the only category of questions on offer. Questions are a mix of true or false and multiple choice questions, each with four options. Some are nice and easy:


> 'Questions are a mix of true or false and multiple choice questions, each with four options.'

"What's the minimum age for the use of mouthwash?" However, some need a little more thinking: "What pathway does fluoride inhibit?" Others are more diagnostically inclined with the question presenting a patient scenario and you having to arrive at a diagnosis. Note, if you get a question wrong it doesn't immediately tell you the correct answer, although because questions randomly repeat themselves, you can have another go at it in the hope of getting it right, while consolidating the rest. If you're feeling like a challenge you can also set the number of "lives" to three, five or seven, which allows for that many incorrect answers until the questioning ends – the aim being to improve on your high score without running out of lives. The app is available in the Lite (free) version and a paid for version, *iStuDent MCQ* for £1.49, which has a much broader range of question categories. Both are available for iOS from the *App Store* only, so if you're looking for *Android* or *Windows* versions, you won't be able to download this. Overall, a nifty little app but the Lite version is a tad too light in content. **Nehal Doshi, third-year dental student, Barts and the London** ■


©iStockphoto/Thinkstock

Joining the Army as a dentist allows you to practice your skills world wide. You would be working in unusual circumstances and in remote locations, which can be challenging, as the leader of a team responsible for the dental health of serving personnel.

It takes a huge amount of resources, manpower and risk to get a patient to a dentist while deployed on military operations. At Careers Day, Major Fiona Cunningham, who has served in Germany, Cyprus, Kenya and Afghanistan, will give delegates an understanding of life in the armed forces, the challenges of providing military dentistry, and describe the full-time and part-time careers available.

Or for those who would prefer a short-term voluntary post, there will be a presentation by Bridge2Aid. It will describe the organisation's focus on health-worker training and working in partnership with the Tanzanian Ministry for Health to make a long-term sustainable difference to the lives of thousands of people.

It will take you through the ways in which you can get involved in Bridge2Aid's work, not only to make a real difference to people in desperate need, but also to benefit your personal development and your career. You will hear how short-term volunteering makes a huge long term difference to all involved.

Careers Day 2015 will be held on Friday 13 February 2015 at Senate House, London. For more information please visit www.bda.org/careersday

# WORKING FOR YOU

The BDA has over 30 committees, each dealing with a wide range of issues. From general practice and the community dental service to salary levels and regulatory requirements, they are at the forefront of dental politics, representing BDA members on key issues that affect their careers. In this regular column, *BDJ Student* will be finding out more about what really happens at the coalface of your trade union. This issue we ask **Roshni Heaton** from the BDA Student Committee to explain a little about its role.

The past few months have been action-packed for all dental students, especially those on the BDA Student Committee. With two representatives from each UK dental school, our aim is to look at the political and financial issues affecting dental students, and feedback student opinion to the rest of the BDA. We work hard to make sure the student voice is heard!

One of the hot topics we often discuss is Dental Foundation Training (DFT). As I'm sure you all know, this year's DFT pay cut proposal has been defeated – something we are very proud to have played a big part in. The Chair of the BDA Student Committee, Paul Blaylock, set up the e-petition against the proposed pay cut, and this gathered over 6000 signatures. Committee members also wrote letters to our local MPs and the Department of Health, and did our best to add force to the Facebook and Twitter campaigns as well.

Another aspect of the DFT process we've looked at is the national recruitment day. At recent committee meetings we have compared and contrasted how each university prepares final-year students for their big day and we have discussed how to make the interview process as fair as possible for all students across the UK. This has been fed back to COPDEND (Committee of Postgraduate Dental Deans and Directors) and the Principal Executive Committee (PEC) of the BDA.

Although we haven't graduated yet, the increase in General Dental Council (GDC) fees is another issue that could affect us in the future. Dental students are graduating with even more financial debt than before, so we don't want any more of our pay to be eaten up by increasing GDC fees. The BDA Student Committee is expressing their stance against the increase, along with the rest of the BDA.

> 'At recent committee meetings we have compared and contrasted how each university prepares final-year students for their big day'

As well as tackling the issues above, students on the BDA Student Committee have been busy doubling up as the BDSA Committee. BDSA Sports Day and Conference are set to be the highlights of the dental student calendar and this year also sees the creation of the Douglas Jackson Grant. The aim of the grant is to encourage liaison between dental schools by funding charitable, academic or social projects. It's a great way to increase unity within the student population, so I'd recommend having a look at the guidelines and getting involved if you can. Visit www.bda.org/bdsa for more details.

I've really enjoyed being part of the BDA Student Committee for the past three years. We're continually working to represent the student body and it's great how the rest of the BDA is always happy to hear our opinions. **Roshni Heaton** ■

## TWEET IT

The defeat of proposed cuts to the dental foundation training salary has been pre-occupying the Twittersphere. Here's a taste of the conversation:

**The BDA** @TheBDA

BREAKING NEWS Gov backs down on FD salary cuts. Thanks to all who supported this campaign! http://bit.ly/XUWV89

3:45am, 28 Aug 2014

**Vinay Raniga** @VinayRaniga

@VinayRaniga @TheBDA @Judith_ Husband Great work! Glad to heard it as a prospective dentist from @ QMULBartsTheLon! #StrongerTogether

3:59am, 28 Aug 2014

**Sheila Nguyen** @Sheila_ktn

@Sheila_ktn Thank you @TheBDA!!! Glorious news! Only 5 days before my first day!!: BREAKING NEWS: http://bit.ly/XUWV89

4:12am, 28 Aug 2014

**Khalid Sindi** @teethwise

@teethwise @TheBDA awesome news! Although I am not benefiting from this, but very happy for my fellow graduates :)

4:18am, 28 Aug 2014

**Cristina Parenti** @cristinaparenti

@cristinaparenti @TheBDA Great work! Thank you for your efforts in making my future brighter :) #ProspectiveDentist

4:09am, 28 Aug 2014

If you have any news, views or issues you'd like to see covered, tell the team at *BDJ Student* all about it.

Write to: BDJ Student, British Dental Association, 64 Wimpole Street, London W1G 8YS

Email: bdjstudent@bda.org

Tweet us: @BDA

# GDC vs BDA: WHERE NEXT AFTER THE #ARFHIKE?

**Peter Ward**, chief executive of the BDA explains its ongoing battle to reverse the Annual Retention Fee (ARF) rise

You break the law. You pay the price. Unless of course you're a professional regulator with a track record of failure. In which case you don't. That's the impression much of the profession was left with following December's High Court Judgment on the General Dental Council's (GDC) botched fee rise consultation.

> 'It demonstrated it wasn't clear on its own powers. It claimed it was facing bankruptcy and 'administrative chaos.' And now we've seen the GDC come under unprecedented scrutiny, and found wanting.'

The regulator was found to have acted unlawfully, and in no uncertain terms. The judge denied the regulator its right to appeal and it was ordered to cover costs. But at the end of the day the GDC was allowed to keep the proceeds of an unfair and ultimately unlawful consultation, the court declining to reverse the 55% rise in the annual retention fee.

So why exactly was the GDC allowed to keep its ill-gotten gains? The regulator was able to put doubt in the judge's mind. It suggested that it would not survive the refund, and therefore the only safe course was to keep the fee rise in place.

Obviously this is not the outcome we were hoping for. But what the BDA's legal challenge has revealed is a total lack of accountability at the healthcare regulators. Inefficiency, ineffectiveness - even acting outside the law - there really is nothing they can't really get away with when neither parliament nor government really have the power to call them to account.

In court the GDC made some astonishing admissions. It demonstrated it wasn't clear on its own powers. It claimed it was facing bankruptcy and 'administrative chaos.' And now we've seen the GDC come under unprecedented scrutiny, and found wanting.

We've got used to seeing the regulator being taken to task by the Professional Standards Authority and parliament. In a parliamentary debate just before the ruling Health Minister Dr Dan Poulter, confirmed that he had "not been presented with compelling evidence to justify the increase" and called on the GDC to make "significant improvements." He might want change, the law as it stands means Dr Poulter's hands are tied.

David Cameron once described health regulation as unfinished business for his government. He promised action to "sweep away" the "outdated and inflexible framework" the regulators operate within.

Now this case provides a basis to see those promises translated into action. The BDA is getting regulation on the agenda in parliament, with government and with the other healthcare associations. There is a real crisis facing our regulation and it will require a coherent response.

This case was not the end of the BDA's campaign. The coming General Election means Westminster residents are distracted, and we will have to keep piling on the pressure to secure the regulation we deserve.

We've seen patients and practitioners left in limbo for over 18 months when complaints are raised, and hearings with a £78,000 price tag. We had to take action because health professionals should not have to subsidise failure at their regulator.

From the start we knew that there was more at stake here than just fees. And that fight goes on. **Peter Ward, CEO, BDA**

# SMILE SOCIETY

The KCL Smile Society is an organisation led by students at King's Dental Institute and is an example of how dental students can make a difference to oral health education in the local community.

Members of the KCL Smile Society have decided to get out into the community. They participate in school visits, where they run interactive workshops with children, educating them about looking after their mouths. These may include diet advice, such as sending cans of Coke to the "bad" pile, dressing up as a dentist, and tooth brushing.

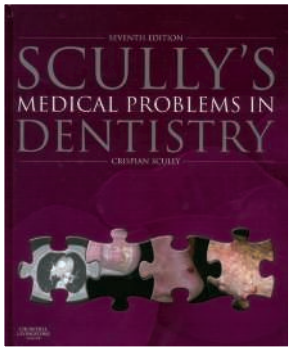
Seeing children fully clad in PPE is not only amusing, but also immensely rewarding. To see how interested and eager children are to learn about looking after their teeth gives us hope that we can each play a role in reducing the incidence of caries we see on clinic.

The workshops run by the Society are free to both students and schools, meaning that the organisation always has a multitude of opportunities for KCL's future dentists to get involved in. Set-up and management of such school events has been a success thanks to a strong organising committee; the Society continues to see a huge level of students putting themselves forward for events year upon year.

Every student who has a chance to run a workshop feels an enormous sense of achievement after each event. It also allows them to develop their paediatric and communication skills – an essential skill for clinic. We hope to continue spreading the word. **Anna Beaven, KCL Smile Society**

REVIEWS: BOOK

# *Scully's Medical Problems in Dentistry (7th ed), Professor Crispian Scully, Hardback, Elsevier Ltd, 2014*



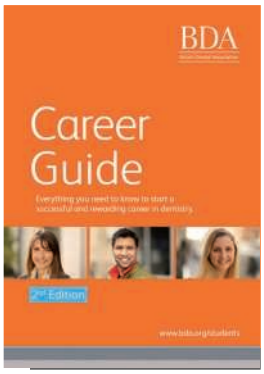

My first impression of *Scully's Medical Problems in Dentistry* was that it's enormous! Now in its seventh edition, the text book seems as close as could be to a completely comprehensive overview of common and uncommon medical problems and their dental relevance. Its shelf-bowing heaviness is testament to its detail, but that doesn't make it a heavy read. There are plenty of bullet points, photos and diagrams, and information is arranged in helpful tables and lists where possible. Often, specific General Dental Council (GDC) guidance is referenced, reminding you continually of the value of the information. A highlight is the biochemical- and haematological-results interpretation table (p46-50) which would have been a great revision sheet for me in my first and second year. And another thing I have struggled with are conditions that are just people's names, like Treacher Collins Syndrome or Ramsay Hunt Syndrome, so I was impressed with the glossary devoted entirely to these. There's also a really helpful chapter that alphabetically lists and explains symptoms and the conditions in which they're seen (xanthelasma, anyone?). Its in-depth coverage of conditions by organ system and other issues,including trauma and disability, will be helpful for students in all five years and beyond.

> 'Its shelf-bowing heaviness is testament to its detail, but that doesn't make it a heavy read.'

However, in a world where information is continually changing, updating, and becoming more evidence based, even the newest and shiniest of textbooks cannot be completely taken for gospel. This is acknowledged in the preface, and links to relevant online National Institute for Health and Care Excellence (NICE) guidance etc are given. And although all the information is undoubtedly out there on the Internet somewhere, there is no substitute for a neat book that has just about everything laid out beautifully in front of you. And, although I certainly won't be trying to learn all of it, it is a great reference book to have on my (fairly sturdy) shelf. **Bex Stockton, *BDJ Student* Student Editor**

## BDA careers lecture and guide book

To help with your career choices, the BDA is touring all UK dental schools with a helpful lecture, which outlines the different career paths open to you as a dentist, what you need to do to get there, plus top tips for succeeding in your chosen dental career.




The lecture is open to fourth-year students and the *BDA Career Guide* will be distributed to members during the lecture. You can preview the guide at www.bda.org/careerguide and you can find out when we are visiting your dental school at www.bda.org/careerslecture.

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# STUDENT VS STAFF

## MANCHESTER

**Hazel Davis** discovers what it's like to study and work in Manchester, by talking to those on both sides of the academic spectrum


STUDENT

➤ Glesni Hitchens, 21
*fourth year student*

"I currently share a flat with four other dental students. The location is ideal. I live next to the main campus and it's less than a ten-minute walk to the dental school and a ten-minute bus ride into the city centre. Living just off Oxford road, the busiest bus route in Europe, is very convenient and commuting around Manchester is definitely not an issue. Everything you need is within the vicinity of the University of Manchester site or in walking distance.

**'Manchester dental school was the first in the UK to introduce outreach clinical teaching starting in the first year.'**

"Clinical experience at Manchester begins at an early stage with the school being the first in the UK to introduce outreach clinical teaching starting in the first year. Varied clinical experience was very important to me and Manchester was able to offer this. Some of the staff are the best in their field and, with the University of Manchester playing home to the Cochrane Oral Health Group, a leader in international research, the school has the highest standards in teaching and research.

"One of things I love most about the school is the staff-student relationship. The students are lucky to have outstanding staff. They are approachable and more than willing to help and support students at any given opportunity, but most of all they are fun. There is a lot of academic and non-academic help and support from both staff and students. Our first-year students have a peer mentor scheme from the start, which partners a first-year dental student with a third year. In my experience this was invaluable for settling in.

"Our Dental Society, MDSS (Manchester Dental Students Society), is made up of 18 annually elected fourth-year students. I am currently the co-president. It is our role to organise the social calendar, including some of the bigger events such as the Annual Dental Ball, halfway meal, Halloween Enigma and our festive celebrations.

"We love getting together with our Northern neighbours – Liverpool, Leeds, Sheffield and UCLAN dental schools – organising joint socials throughout the year. Last October we were able to take 100 dental students to the national BDSA Sports Day in Birmingham. We're hoping to take a large group of Manchester students to the BDSA Conference in London in March and each year we organise two trade fairs where companies come to discuss their role in the dental industry with the dental students.

"This year the school will be holding its first recognised dental volunteering event as part of the student timetable, presented by DentMan Global Oral Health Forum. This is a recently founded joint global health initiative by Manchester Dental School and the Dental Hospital. Volunteering overseas and in the UK is an excellent way to experience new clinical and teaching environments, as well as gaining an insight into different cultures. I feel this initiative has introduced another aspect to dentistry for dental students here and it's something we hope to develop further.

"There are downsides. Manchester can be really hard work in the rain. I am not sure the label 'the rainy city of the UK' is completely true, but I do try to avoid leaving the flat without an umbrella. Moreover, in such a large and busy clinical environment with so many different aspects to a dental degree, ensuring student and patient feedback reaches the top can be a difficult task.

"However, this year the school has worked hard to ensure that all student and patient concerns and issues are heard. With the introduction of iPad systems in the reception area and two individuals from each year group elected by their peers to represent them at monthly staff-student liaison committee meetings, the school is constantly building and developing on valuable feedback." **Glesni Hitchins**

"I've been here for just over two-and-a-half years. I teach both postgrads and undergrads and have overall responsibility for the undergraduate programmes and the postgraduate programme in periodontology.

"I'm originally from Abingdon in Oxfordshire and I live in a small town in North Hertfordshire, called Baldock, and do a weekly commute to Manchester.

"The staff-student relationship is very healthy here. As well as our academic staff, we have staff who are DFY1 trainers, specialists, very experienced general practitioners and even members of GDC (General Dental Council) panels. There is a staff-student liaison committee meeting held every other month with representation from the academic staff and student body, including the student social, sport and ball committees, with NHS representation from the University Dental Hospital and staff from the library and other supporting areas.

"Because like most schools we are relatively small in numbers we tend to get to know our students pretty well so we are often approached by them for advice. More formally, each student is allocated an academic advisor during their time here, who meet with students each term or more frequently if necessary. Apart from that, being part of one of Europe's largest universities means that our students are able to access all manner of support from the broader university.

"There are two balls a year, which are well supported by staff. We also have staff-student football and have had hockey and cricket matches. We are looking at golf for the spring. There are staff-student quiz nights and many other events in the varied social calendar. I'm, however, far too old to go out at night.

STAFF

➤ Professor Kevin Seymour, *Director of Undergraduate Education and Programme Director – MSc Periodontology*

**'I can see enormous opportunities up here and my experience of the local practitioners is that there is some excellent dentistry being done in the North West'**

"There are many advantages to studying dentistry outside of London. There IS life outside E1. I can see enormous opportunities up here and my experience of the local practitioners is that there is some excellent dentistry being done in the North West with a great involvement of GDPs not just in local planning but in the wider arena. Dentistry is thriving up here.

"As I am the undergraduate-programme director, it's down to me to make the course better but I think it's true to say that we are always trying to improve things in the programme and we have a number of very dynamic people working towards that, particularly in terms of our feedback and assessment, which are our current areas of action. **Professor Kevin Seymour** ■

# INTERCALATING

With dentistry already a long course, it might be difficult to imagine why people would want to extend it even further, but some undergraduates see intercalating as an opportunity to enhance their university experience. **Bex Stockton**, *BDJ Student*'s student editor, decided to find out what it means to intercalate and how it can help your future career.



Last year in the UK, only 19 out of around 1100 second year students took a year out of their BDS programme to intercalate. That's less than two per cent who choose to undertake an extra non-dental degree. Clearly intercalating is not a popular choice, but should it be?

Intercalating means pausing your BDS studies to complete a whole extra degree, usually in one academic year. Students tend to do this after their second year of study on the BDS course, but occasionally after the third or fourth.

Each dental school has its own list of subjects available, which are usually closely linked to dentistry, be it a BSc, a BMedSci, MRes, or something else. Each degree would usually take three years to complete, so successfully to finish it all in one year takes a lot of hard work and dedication.

According to Helen Falcon, the Chair of the UK Committee of Postgraduate Dental Deans and Directors (COPDEND): "The general feeling is that having an intercalated degree is immensely helpful to those students who may be considering a career in academic dentistry, and should lend a competitive advantage to those entering specialty training."

However, despite this view, the number of dental students who choose to intercalate doesn't seem to be rising.

"We have very few dentists that intercalate, despite it being something we encourage our students to consider," says a senior clinical lecturer, who does not wish to be named. "Certainly compared to medics, our numbers are very low. We have asked our students for feedback as to why this is, and they say, because the end goal is to become a dentist, a year out would delay their progression to this and be of little benefit if they want to work in general practice."

Lauren Aronson, a fourth-year dental student at the University of Manchester, agrees: "I enjoy clinical dentistry too much! I'm eager to get out and start practice. If I want to specialise later, I feel another dental qualification would be better than intercalating."

Another explanation could be the relatively high intake of dental students that already hold another degree before they start the BDS.

For those who have already made the decision to intercalate, it provides a unique opportunity to fit in a second degree into a much shorter period, making it a time-efficient way of achieving two degrees.

"I knew I wanted to intercalate before I even applied to do dentistry," says Manás

**'It's not easy, but it sets you apart from other BDS graduates and allows you to gain a greater insight into another field of study.'**

Dave, a third-year dental student from University of Manchester, who intercalated last year to do a BSc in Pathology. "It's not easy, but it sets you apart from other BDS graduates and allows you to gain a greater insight into another field of study. I particularly admired the work of the maxillofacial histopathologists I shadowed and I can see myself perhaps pursuing that career in the future."

Manás' research project on signalling molecules in leukaemia saw him start work on his lab experiments at 7am five days a week, and often not finishing until 5pm.

"And as I hadn't yet covered cancer on the BDS course, I was playing catch-up at first, with lots of extra work at weekends. My social life inevitably suffered that year," he says. "But I got on really well with everyone on my course despite being the only dentist amongst medics!"

However, the hard work eventually paid off: "The vast skills you learn, the new friends you make, and that unforgettable moment when you walk up to collect your degree undoubtedly make it all worth while. And the research, continued by the group, is in the process of being published."

Another of the brave few that intercalated last year was Olivia Johnson King, a fourth year from King's. Her intercalated degree in Regenerative Medicine and Innovation Technology was very relevant to the BDS programme.

"Regenerative medicine is a fairly new field of research, but is becoming very poignant in dentistry," she says. "My course involved lectures on tissue engineering, biomedical-materials science, stem-cell therapy, bone regeneration and biomedical imaging, as well as a nine-month dental research project, where I chose to look at the use of bioactive glass technology in operative dentistry. In addition, the innovation technology aspect of the course involved employment law and accounting - a useful introduction to setting up a business such as a dental practice."

Olivia even managed to squeeze in a module of French contemporary culture as part of her BSc. "It was a great opportunity to have a break from the scientific field!"

The transition back into dentistry from the intercalation year is daunting for some. Olivia and Manás both found their dental schools provided refresher sessions over the summer to ease them back into clinical skills.

"The clinical skill comes back very quickly," says Olivia. "Just like riding a bike!" You also have to get used to a whole new year-group, meeting lots of new people and seeing less of your old friends.

"I still live with two of my friends from my original year-group," says Manás. "And on entering the room for my first lecture this year, I was half expecting to see them. It felt strange to be greeted by a sea of new faces. But everyone in what used to be the year below was very friendly and went out of their way to say hello and make me feel welcome. Within a few days I had made some good friends."

If you are a first or second year (or even a third year) and considering intercalating, speak to your Head of Year about your options, as the courses offered differ slightly from school to school. **Bex Stockton** ■

## Further information

### Which courses can I do?

Options vary between dental schools so have a look on your school's website or speak to your Head of Year. Some of the commonly available courses are:

- Biochemistry
- Biomedical Engineering
- Global Health
- Medical Education
- Molecular Medicine
- Neuroscience
- Pathology

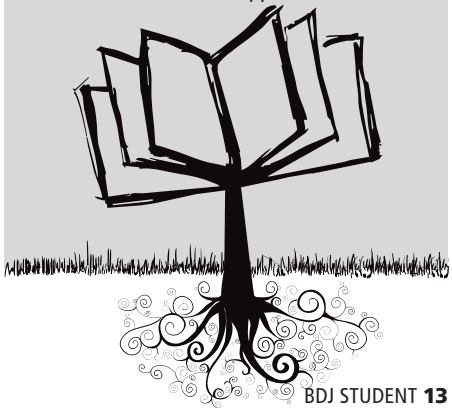
### What about funding?

Doing an intercalated degree can be expensive. The time you will spend studying during your intercalated is often up to 11 months, which you will have to budget for especially if you will be living away from home. The intensity of the course may also prevent you from keeping up a part-time job. However, your dental school may have its own funding scheme, so it is worth asking.

If you are eligible for the NHS Bursary Scheme, which would usually provide full funding of tuition fees for your fifth year of study on the BDS scheme and you decide to intercalate, you will then be eligible for NHS funding in both your fourth and fifth year on returning to your BDS degree. See http://www.nhsbsa.nhs.uk/Students/3313.aspx for more details.

### Will it increase my employability as a dentist?

Since your dental foundation training year allows you to consolidate your clinical skills in a supervised environment, an additional qualification other than the BDS/BChD, whether intercalated or not, does not affect employability as a dentist. Individual employers may have a preference for colleagues with additional qualifications, but there is no evidence to support this.



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# ETHICAL DILEMMA

## **Susan N'Jie**, dento-legal adviser for the Dental Defence Union(DDU) asks what you should do if you have a celebrity as a patient

*I recently treated a well-known professional footballer and yesterday I received a phone call from a national-newspaper journalist asking for an interview. He had already spoken to the footballer and knew quite a lot of information about the treatment I had provided and said how happy the footballer was with the work. Up to now, I haven't told anybody about this patient but the publicity would be brilliant for my practice. As the patient has already confirmed he has had the treatment, can I comment?*

It is always heartening to hear that a patient is satisfied with their treatment and especially nice to know they are talking about it to others. However, even if a patient chooses to speak publicly about their dental treatment, this does not mean that you can also comment freely. If you do not have the patient's permission to do so, even confirming to a journalist or any other third party that someone is a patient is a breach of confidentiality, so it is important that you think carefully before responding to a journalist or anyone else who is asking for information about a patient.

When considering whether or not to disclose information about any patient, you should always act in the patient's best interests and follow the General Dental Council's (GDC) guidance on confidentiality in Standards for the Dental Team (2013). This advises dentists to protect the confidentiality of patients' information and only use it for the purpose for which it was given (paragraph 4.2) and that information should only be released without consent in exceptional circumstances (paragraph 4.3).

The GDC also provides advice to dental professionals on publishing information in the media. Standard 9 states: "You should not publish anything that could affect patients' and the public's confidence in you, or the dental profession, in any public media, unless this is done as part of raising a concern.... In particular, you must not make personal, inaccurate or derogatory comments about patients or colleagues."

A request from a journalist is unlikely to fall into the category of an exceptional circumstance, so if you are thinking of commenting, you need to check that you have the patient's permission first.

**'Even if the patient agrees to providing information to the media, it is important that the content is explicitly agreed beforehand.'**

Even if the patient agrees to providing information to the media, it is important that the content is explicitly agreed beforehand. It can be difficult to do this if you are interviewed by telephone or in person because interviews with journalists can be high- pressure situations in which you cannot be certain, in advance, exactly what you will be asked.

Having considered all the potential pitfalls, in this case you may decide that it is best not to be interviewed by the journalist and simply to state that you "Cannot comment due to patient confidentiality". Many journalists recognise this ethical duty and will respect your decision not to speak

It is important for dental practices to have a clear written protocol for dealing with the disclosure of patient information, that all staff are made aware of it, and are appropriately trained about patient confidentiality.

A practice may wish to appoint and train a current member of staff to co-ordinate and deal with enquiries from third parties that may involve sensitive or confidential information, including the media. As a central point of contact for any such enquiries, that member of staff can prepare a response in line with the practice protocol. **Susan N'Jie** ■

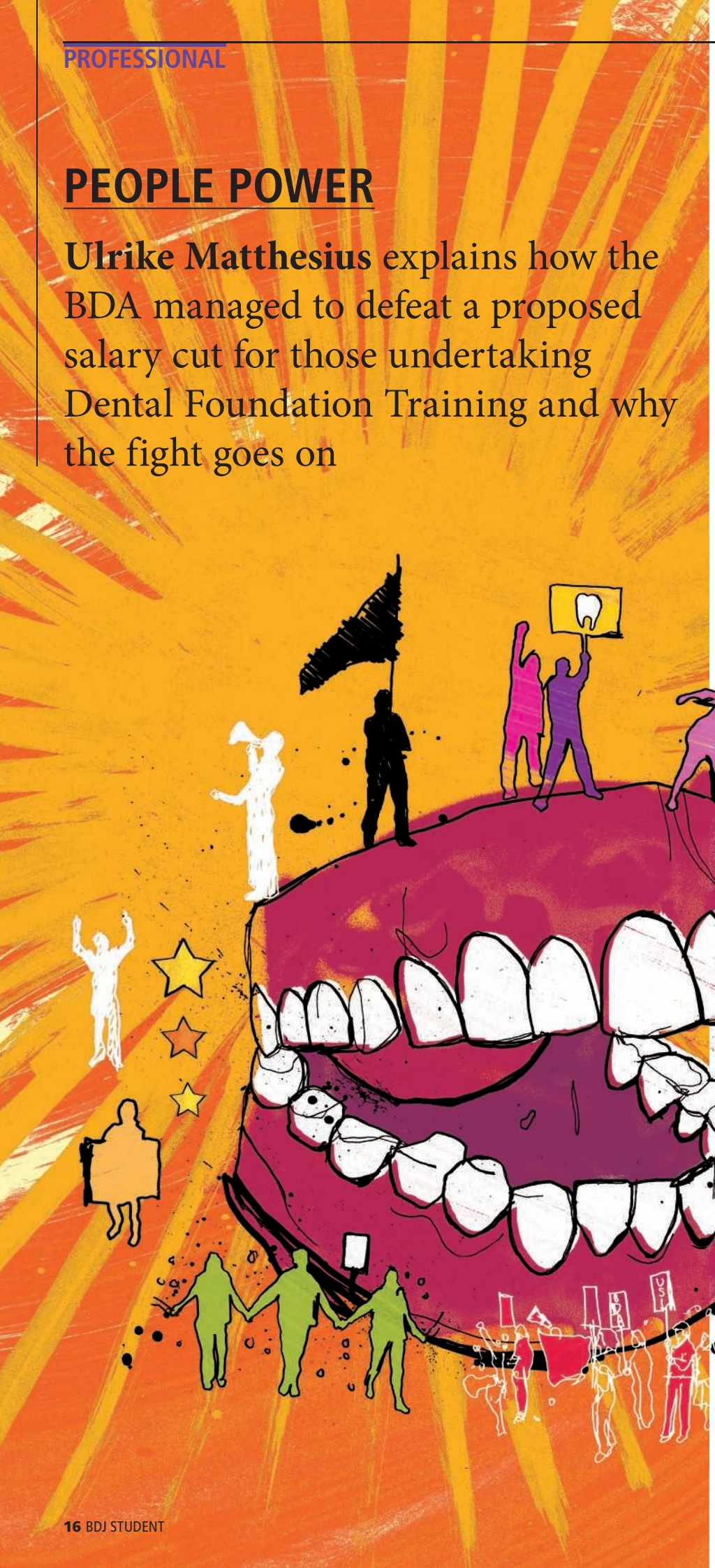
## Key points to remember

- Just because a patient chooses to speak publicly about their dental treatment, doesn't mean you can.
- Even confirming a patient's name to a third party could be a breach of confidentiality.
- When considering whether or not to disclose information about a patient, your priority should be acting in the patient's best interests.
- Refer to the relevant sections in the GDC's guidance Standards for the dental team for information on confidentiality and dealing with the media.
- Information should only be released without consent in exceptional circumstances – a journalist's request is unlikely to fall into this category.
- Even if a patient does consent to you speaking to a journalist, it is important that you agree exactly what they are happy for you to discuss.
- Dental practices should have a clear written protocol for dealing with the disclosure of patient information and all staff should be aware of it and appropriately trained about patient confidentiality.
- A practice may wish to appoint and train a member of staff to co-ordinate and deal with enquiries from third parties, including journalists.

For more information, visit www.the-ddu.com

# PEOPLE POWER

**Ulrike Matthesius** explains how the BDA managed to defeat a proposed salary cut for those undertaking Dental Foundation Training and why the fight goes on



When the Government announced it was planning to cut the salary paid to those undertaking Dental Foundation Training for September 2014 by around £2000, there was upheaval among the profession. The BDA immediately signalled its complete opposition to the proposal and started a campaign to highlight the issue and drum up support for the youngest members of the profession.

The proposal for the salary cut was officially put 'on the table' as one of a number of efficiency savings being sought by NHS England at the start of April 2014. The BDA moved quickly to condemn the proposal, warning that it would be seen as an attack on the most vulnerable members of the profession. The proposal effectively was a cut of nearly eight per cent to the salary.

The Department of Health clarified that it was keen to press on with the cut, writing formally to the BDA to re-assert its intention to reduce the salary to £28,076 and setting a deadline of the end of May 2014 for comments.

## Fighting the pay cut

The BDA's Student Committee set up an e-petition in April which immediately gained high levels of support and reached over 6800 signatures by the end of the campaign.

The BDA also set up a lobbying campaign, all the while ensuring that NHS England and the Department of Health knew we were not allowing this issue to quieten down. Members who expressed an interest to be active were also provided with information on how to contact their MPs, as well as given a brief on the topic. This included specific

points on student-debt levels, the detrimental effects on morale and retention of dentists in the NHS, and the worries students already faced in terms of a shortage of dental foundation training (DFT) places.

We also encouraged all members to keep the topic in the minds of those concerned through specific Twitter hashtags and the BDA's Facebook page. Social media proved extremely useful as part of this campaign.

In response to the formal proposal, we highlighted that a reduction to a level comparable to that of the basic salary for foundation-year-two doctors was completely inappropriate as the two positions were not equivalent; the comparisons made between the two in terms of care provided and relative earnings were not correct. In addition, future reviews of the doctor's foundation-training salary were likely to impact negatively on dentists if the salaries became linked in this way. We also emphasised that applicants had already accepted placements in January 2014 for places in March and September 2014, and had done so on a specific salary expectation, which should not now be reduced.

We also opposed an argument that the proposed reduction in salary was a generous offer in comparison with what could have, apparently, been proposed. We illustrated the level of debt of current students and future expectations of debt levels. Furthermore, the saving expected to be generated by the reduction (0.2 per cent), represented a negligible saving to the NHS compared with the impact that an eight per cent reduction would have had for an individual.

In terms of future recruitment to the profession, we also made the point that a salary reduction for the first year after graduation, combined with increasing tuition fees for a five-year course, would discourage potential applicants who would make great future dentists.

Our consultation response can be seen on the BDA website.

## Legal action

Throughout early summer, the messages we were receiving from the Department of Health indicated that the salary cut would go ahead regardless. This caused us to consider another approach: the legal route. We wrote to NHS England and the Department of Health to ensure they were aware that we were contemplating taking them to a judicial review over the issue.

On 28 August 2014, the BDA received notice that the Government was backing down on the proposed cut, and the health departments in Wales and Northern Ireland equally confirmed that no pay cut would be implemented.

This was a victory for the youngest members of the profession, and for common sense – a cause for celebration. But efficiency savings are still a reality in the NHS and it is important to be aware that dental budgets are not immune.

## A job for all UK graduates

Dentistry had another reason to celebrate in 2014 because all eligible UK graduates received a DFT place that year. The past few years have been full of concerns about the available number of DFT places, and in some years, between 30 and 40 graduates were left without places. But the efficiency savings could well take their toll on place numbers in the New Year, and this is why we are watching developments very carefully. At the time of writing, the available number of training places is not known, but by the time you read this, these figures and what they mean for this year's applicants are likely to be out in the open and we will already have a campaign strategy in place to address any issues.

We are determined to stand up for the next generation and fight your corner.

Over the next pages we talk to some key players involved in the campaign.

**'We highlighted that a reduction to a level comparable to that of the basic salary for foundation-year-two doctors was completely inappropriate as the two positions were not equivalent; the comparisons made between the two in terms of care provided and relative earnings were not correct.'**

## THE DENTAL STUDENT

Anish Patel – *Second year dental student at Kings College London*

*How does it make you feel as a dental student to know that your salary when you graduate may be under threat?*

The concern of potential salary reductions, coupled with the extremely demanding and taxing nature of the undergraduate BDS course, can make you feel quite nervous and anxious about the world of dentistry, which we will eventually set foot in. It can also be demotivating to a certain extent, particularly when as students we have relatively little influence about the changes that will probably impact us most.

*Does it make you worry more about your student debt?*

Taking into account the five-year duration of the BDS programme, £9000 tuition fees and the increasing cost of living, the prospect of a reduced salary can heighten the worries associated with student debt. With the relatively new student finance system, where repayments are also associated with a base rate and inflation, improved budgeting is something that is really important.

*Do you think your graduate salary/ student debt will affect where you eventually end up practising (NHS/ private/hospital)?*

To meet higher debt repayments I think the demographics of dentistry and the type of dental setting in which care is provided will become a more significant factor. However, the extent this will impact will vary according to the areas of dentistry individuals are naturally interested in.

## THE NEGOTIATOR

**Dr Judith Husband** – *Vice Chair of the British Dental Association's (BDA's) Executive Board and Chair of the Education and Standards Committee*

*Why did you feel the issue of a reduction in the DFT salary was so important that it merited potential legal action?*

The BDA is an organisation that exists to protect and support its members. A salary freeze for DFT had already been in place and a reduction in pay had been mooted for years. We had been fighting hard to protect the most vulnerable in our profession, those seen as an easy target. The proposals, and very rushed consultation, one that was generally believed to be a "done deal" was an attack on all dentists. The Principal Executive Committee (PEC) decided immediately to seek legal advice, the outcome of which gave us the belief that further information was needed and the potential for legal action was an option.

This outright attack on young dentists is key to why the BDA exists and having it occur "on my watch" meant everything reasonable had to be explored and exhausted to defeat it - we all have to look in the mirror and know we did our best. This was one of those moments in my life.

*What future issues did you see for young dentists if the BDA had not taken up the fight?*

This would have opened the door to further cuts in DFT salary, with profound implications on all young dentists in salaried posts in the NHS and everybody's pension would be affected. It would also be a marker in the sand, the profession could be picked off gradually. By demonstrating our unity and desire to protect each other we have sent a powerful message to all decision-makers about pay and conditions. Every dentist must now start to believe that we can change the status quo. We have to stick together and use every means at our disposal - the law, petitions, social media and negotiating forums.

*How will the BDA counter a potential shortfall of DFT places starting in 2015?*

We will continue to lobby government and relevant individuals, building on the great success of last year. The Department of Health finally did the right thing by funding additional places, and this must not be an exceptional event - it must be the norm. UK taxpayers invest heavily in training dentists, as do the individual students, and this investment must not be wasted. The tragic cost to individuals of qualifying without a DFT place should not be inflicted upon anybody ever again. Finals are stressful enough without the fear of being unable to work.

*Do you have any other comments?*

There was initially a general acceptance of the proposed DFT pay cut from many in the profession, noting that the pay was still good for a new graduate. This defeatist approach is unacceptable we must fight to improve working conditions and patient care, and never accept that the world will become a harsher, more difficult place.

We need students and young dentists to be at the centre of the BDA - your views are unique and the PEC must be informed and advised of what matters. Working together, looking after each other and ensuring actions are taken by those in power are fair and legal has to be our mission.

Together we can make a difference.

**'Every dentist must now start to believe that we can change the status quo. We have to stick together and use every means at our disposal -the law, petitions, social media and negotiating forums.'**

## THE CAMPAIGNER

**Jacob Mercer-Jones** – *BDA Student Representative for Leeds Dental School*

*How did you help to campaign on these issues?*

All the BDA reps helped to campaign via Twitter by trying to get the message out there to students all over the UK (and hopefully our friends studying abroad), to encourage them to sign the e-petition. We made it clear that anyone could sign the petition - not only dental students. We also posted on our dental schools' Facebook groups encouraging other dental students to get involved with some selfies on Twitter to promote the e-petition.

*Why are these issues important to you?*

This is really important to us because we will be the ones most affected by the outcomes of these decisions in a few years' time. A pay cut of £2000 would be a massive blow to all trainee dentists, and it'll be worse for those who might not even get a DFT place.

**'A pay cut of £2000 would be a massive blow to all trainee dentists, and it'll be worse for those who might not even get a DFT place.'**

## THE COMMITTEE CHAIR

Dr Paul Blaylock – *Chair of the BDA Student Committee*

*What did the Committee do to campaign on these issues?*

The Student Committee was instrumental in the DFT salary campaign. It was our initial debate that came up with the basis for the campaign. It was important to raise awareness of the issue, which was not properly publicised by those proposing the reduction in salary and our opposition to it. As the Chair I created a government e-petition, which has been signed by over 6800 people. It was the most successful BDA petition ever, as it brought together dental students and the whole of the profession to oppose this proposal. The petition was promoted to all dental students by the committee members at their respective dental schools.

Many committee members wrote to their local MPs asking for their support, and we received a number of responses. As Chair I wrote to all MPs with a dental school in their constituency. There was also a large social-media campaign, especially on Twitter using the #DFTPay hashtag. Students across the UK joined in, with many committee members taking part and tweeting pictures of themselves with messages highlighting their role as the future of NHS dentistry. The committee contributed to the BDA's official response to the consultation. When we were initially faced with the setback of being told that the pay cut was to go ahead, we did not give up, and eventually we were successful in getting the pay cut overturned with the support of the whole of the BDA.

*Why are these issues so important to students?*

The proposed DFT pay cut of over £2000 was as an attack on the most vulnerable members of the profession at a stage in their career immediately after graduation when they are heavily in debt and can least afford an unjustified pay cut. There was no basis for the pay cut, which was felt to be deeply unfair. The comparison with medical graduates was flawed, and to single out this group of NHS employees to suffer a pay cut had to be vigorously opposed. Every dental student is more than £2000 better off on graduation as a result of our successful campaign, which is great news.

**'The proposed DFT pay cut of over £2000 was as an attack on the most vulnerable members of the profession at a stage in their career immediately after graduation when they are heavily in debt and can least afford an unjustified pay cut.'**

*Do you have any other comments?*

It has been a busy year for the Student Committee, and we have worked well together to achieve great success with the DFT pay issue. I believe that this success can be used as a springboard to lead us on to further successful campaigns on issues that are important to all student and dentist members of the BDA.

## Fighting hard on your behalf

We are the trade union and professional body for dentists and dental students in the UK. As a not-for-profit, member-owned organisation, our sole purpose is to help and support you, throughout your time at dental school and as you embark on life in practice.

We fight on important issues for dental students and the profession:

1. We won a battle to overturn the proposed £2,000 pay cut for Foundation Dentists in 2014
2. We have successfully campaigned for all eligible UK graduates to have Dental Foundation Training places in 2014
3. We successfully campaigned for priority to be given to UK graduates in Dental Foundation Training recruitment
4. We have fought against the General Dental Council's increased annual retention fee
5. We are fighting for a fairer NHS contract for dentists in England, Wales and Northern Ireland
6. We pushed for tooth whitening to be carried out only by dental professionals
7. We won significantly improved pay and holiday entitlement for salaried services staff in Scotland
8. We successfully campaigned to reduce substantial cuts to the Northern Ireland dental budget
9. We have led international efforts to secure a global, legally-binding treaty allowing a gradual phase down of the use of dental amalgam, rather than a rapid outright ban
10. We closely monitor dental student debt levels and the impact this has on student lives and future career choices.

Only the BDA has the remit and authority to stand up for the profession in this way. When we speak on behalf of thousands of dentists and dental students, others listen.

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# HOW TO WORK IN… PAEDIATRIC DENTISTRY

**Claire Stevens**, a consultant in paediatric dentistry, tells *BDJ Student* about her career so far

*BDJ Student*: *Can you explain your job?*
Claire Stevens: As a consultant, I am responsible for a large team of dentists, dental students, nurses, therapists and support staff who help me to co-ordinate tertiary care for patients from birth to 16 years. Tertiary care is more complex than the care provided in practice or the Community Dental Service. For example, we cater for children with complex dental trauma, those requiring multidisciplinary care or those whose medical history complicates their dental treatment. I also provide training for dentists who are specialising in paediatric dentistry, as well as therapists and dental nurses. My week consists of new-patient clinics and a theatre list, as well as teaching sessions and review clinics.

My work as honorary secretary of the British Society of Paediatric Dentistry (BSPD) sees me co-ordinate the day-to-day running of the Society. I might be submitting a response to a government consultation, helping to write a press release, updating our Facebook page or anything really which helps to keep the oral health of children in the news.

**'I love the fact that I am constantly challenged. By the end of the day I am both physically and mentally tired. I never find myself watching the clock – I haven't got time!'**

BS: *Can you tell us about your career pathway?*
CS: I decided that I wanted to be a paediatric dentist in my fourth year of dental school. We had a consultant called Peter Crawford who gave us a lecture on paediatric dentistry and I was hooked. He was a complete inspiration to me and guided me throughout dental school and until I became a consultant. It is not an understatement to say I wouldn't be where I am today had it not been for Peter.

## *Dr Claire Stevens CV*

| | |
|---|---|
| **1977** | Born in Chelmsford |
| **2000** | Graduated from Bristol |
| **2000-2002** | General Professional Training, Newcastle Dental Hospital and 137 The Dental Practice |
| **2002-2003** | ***Associate***, Brunswick Village Dental Practice |
| **2002-2003** | ***Honorary Clinical Tutor in Paediatric Dentistry***, Newcastle Dental Hospital |
| **2003** | ***Community Dental Officer***, Tees Community Services |
| **2003** | ***Locum SHO in Paediatric Dentistry***, Newcastle Dental Hospital |
| **2003-2004** | ***Senior Dental Officer***, Dental Public Health |
| **2003-2007** | ***Specialist Registrar in Paediatric Dentistry***, Newcastle Dental Hospital |
| **2007** | ***Senior Dental Registrar***, Women's and Children's Hospital, Adelaide, Australia |
| **2007** | ***Locum Senior Dental Officer***, Tees Community Services |
| **2007-2008** | ***Locum Staff Grade***, Central Manchester University Hospitals NHS Foundation Trust (CMFT) |
| **2008-2009** | ***Fixed Term Training Appointment***, CMFT |
| **2009-present** | ***Consultant in Paediatric Dentistry***, CMFT |

After Bristol, I moved to Newcastle to undertake a two-year General Professional Training programme, which provided me with a fantastic base from which to specialise. I also worked as an honorary clinical tutor, in general practice, the community dental service and in dental public health before beginning my specialist training programme in Newcastle. I then travelled to Australia before completing my post-Certificate of Completion of Specialist Training (CCST) training in Manchester.

**BS:** *What are the best aspects of the job?*
**CS:** I love the variety of my work. No two days are ever the same as I never know who is going to walk in through the door. I love the fact that I am constantly challenged. By the end of the day I am both physically and mentally tired. I never find myself watching the clock – I haven't got time! I really enjoy working with children and young people. They keep you on your toes! As a consultant I set up an intravenous-sedation service for young people who are particularly anxious about dental treatment. The reward I get from successfully treating a phobic patient is immeasurable. I see the fact that I have the skills to help these patients as a real honour.

**'From a clinical perspective, I was advised to treat every patient as if they were a member of my own family. If you work along these lines I don't think you can go far wrong.'**

**BS:** *And the worst?*
**CS:** I honestly don't dislike any aspect of my job. I moved to part-time working when I became a Mum two years ago. Although it is great to have a balance with my work and home lives, I do miss some of the sessions and roles I no longer have time to fulfil at work. I guess the frustration is that I don't have time to do everything I want to be able to achieve – I need more hours in the day.

**BS:** *What advice would you give someone who is interested in your area of work?*
**CS:** I would recommend joining BSPD as a student. It is a brilliant way of finding out what is going on in the specialty and keeping up to date with guidelines plus you get the *International Journal of Paediatric Dentistry* as part of your subscription. For only £15 a year I think that is really good value. We also run annual scientific conferences and in 2015 we are hosting the International Association of Paediatric Dentistry Conference, which is shaping up to be really exciting. You can find out more about BSPD, our conferences and guidelines along with information on how to join on our website (www.bspd.co.uk).

**BS:** *What can dental students do to put themselves in the best position to pursue a career in paediatric dentistry?*
**CS:** Always keep an eye on the long game and work towards getting yourself in the best place for applying for jobs when they come out. Attending BSPD regional branch meetings will allow you to network with colleagues in your area as well as adding to your continuing

## Interested?

### How can I train to become a specialist in paediatric dentistry?

- To train to be a paediatric dentist within the United Kingdom, you should apply for a specialty-registrar training post on a recognised paediatric-dentistry-training programme: post BDS/BChD qualification, you will need to gain broad experience in general dentistry including hospital, community and general dental practice. A two-year foundation training programme or equivalent programme would give the desired range of experience. In addition, a maxillofacial post is highly desirable, as is some additional experience of treating children.
- While the Diplomas of Membership of the Joint Dental Faculties (RCS England), the Faculty of Dental Surgery (RCS Edinburgh/RCPS Glasgow) or the Faculty of Dentistry (RCS Ireland) remain useful indicators of completion of this period, it is not essential that a candidate holds one of these qualifications.
- You should carry out some audit projects and aim to have one or two articles published. Attending local British Society of Paediatric Dentistry (BSPD) meetings will enable you to meet colleagues with similar interests and learn more about the range of the specialty. These types of activities will help when applying for a specialty-training post.
- Once accepted on to a training programme you need to successfully complete your supervised training programme and pass the Membership in Paediatric Dentistry examination. It is expected that a trainee who enters whole-time specialty training in paediatric dentistry with no relevant prior training in the specialty will complete training in three years. Part-time specialty training is also possible and would usually be completed in around five years.

### Where can I carry out specialty training?

- Programmes for paediatric-dentistry-specialty training are available in the Hospital Dental Service with a number of programmes being linked with the Salaried Dental Service.
- There is also the opportunity of carrying out an academic clinical fellowship programme which provides both a clinical and academic training environment designed to provide support for individuals who have potential for development as a researcher. These programmes are also three-year appointments providing full clinical training in paediatric dentistry and completion of a research MSc, at the end of which the trainee is expected to sit the Membership in Paediatric Dentistry examination. The expected career pathway would then be a PhD and further specialist training to achieve the additional competencies necessary for appointment at consultant level.

### Where can I get further information?

- The paediatric-dentistry consultants and specialists at your local dental school and hospital are a good first point of contact. The relevant postgraduate deanery can be contacted for information on the local application process.

professional development (CPD) with well-respected speakers. In terms of career posts – I always respect applicants with experience in maxillofacial or oral surgery, primary care and the community dental services. Even if you wish to end up working in a hospital it is invaluable to know what everyone else is up against.

BS: *What is the best piece of career advice someone has given you?*
CS: My Dad always told me you should look forward to going into work every day. I don't work to live and I think that is really important. From a clinical perspective, I was advised to treat every patient as if they were a member of my own family. If you work along these lines I don't think you can go far wrong.

BS: *What are your career aspirations for the future?*
CS: I am currently exploring how I might be able to work more flexibly as I live in Newcastle, despite working in Manchester! I have started writing a blog (**www.toothfairyblog.org**) which aims to provide parents with pragmatic, yet evidence-based advice for looking after their children's teeth. I don't know where it will lead but I am keeping everything crossed that it might provide new opportunities that will allow me to continue my work as a consultant but be able to able to spend more quality time with my two young children. At worst, I hope the blog will reach some families who might not otherwise have had access to preventive dental advice.

BS: *Any regrets?*
CS: Erm...not really. That's quite incredible I guess. I suppose I could say I wish I'd said different things in interviews or perhaps that I worked closer to home but I like to look at the opportunities that have arisen as a result of these 'mistakes' or 'failures'. I do believe that everything happens for a reason. We only have one shot at life and I'd prefer to be looking forward.

BS: *Do you have somebody you look up to in the profession?*
CS: I look up to so many people within the profession. If I had to limit it to just one name, I would say Kathy Harley – she was the first woman as well as the first paediatric dentist to be elected Dean of the Dental Faculty, Royal College of Surgeons of England. Kathy is such a strong leader: she is passionate and a true inspiration to me, plus no one power dresses quite like her!

# LIFE AS A SHO

## – My first night on call

In the first of a new column about life as a Maxillofacial and Oral Surgery Senior House Officer (SHO), **Nasar Mahmood**, an SHO at Pinderfields hospital looks back on his first night on call.

My first night on call was a Friday night. I had a handover at 8pm where I was handed the "bleep" or now, as I like to call it, "the little black box of doom". Looking back, the night wasn't so busy, yet it was stressful, mostly because the cases were so different from what I was used to in primary care. Patient one had been drinking heavily, had allegedly been assaulted and had a suspected orbital floor fracture. Patient two had a fractured mandible. Patient three had a laceration on his forehead and patient four had head-and-neck symptoms, which made no sense at the time. The night was spent making sure I "didn't miss anything", which is hard especially since you don't truly know what you are looking out for so early on in the post.

Thankfully, the NHS Trust had made a so-called Survival Guide, which had become my new best friend and, like a best friend, pointed me in the right direction when things became fuzzy. Yet, even with the survival guide, there were challenges that were new. For example, how do you manage a drunk patient who's abusive? How do you check vision in a patient with a swollen eye? You quickly learn how to prioritise tasks as new jobs get added to your list and learn how small details matter – call a radiologist a "radiographer" and you'll find out what I mean.

The first time taking bloods and inserting a cannula on a "real person" (instead of a plastic arm in induction) was nerve-racking. After a second failed attempt the nurse looked straight at me for three seconds without blinking with a "Do you know what you're doing?" look. I quickly learnt that looking back for three seconds and raising my eyebrows slowly somehow signalled to her to make small talk with the patient until I gathered myself together. Who knew the staff had telepathic abilities?

With help from A and E staff doing the second on call, and enough coffee to jump start an Olympic track team, the night went relatively smoothly. The lessons learnt on that first night proved valuable for the nights that followed.

**'With help from A and E staff doing the second on call, and enough coffee to jump start an Olympic track team, the night went relatively smoothly.'**

Five top tips for your first night on call:

- 1. The most important rule of all. If in doubt, ask! You're not expected to know everything but you are expected to ask for advice when you are not sure.
- 2. Say please and thank you – they go a long way in the hospital.
- 3. Don't assume anything – check, double check and then go back and triple check.
- 4. Stay calm in tense situations.
- 5. Know your limits. Trying to be a cowboy won't help anybody and will probably annoy a senior colleague

**Nasar Mahmood**



# PROTECTING YOURSELF AGAINST THE UNEXPECTED

**Sarah Bradbury**, head of marketing and communications at Dentists' Provident, gives you an introduction to protecting yourself against some of life's unexpected events.

When you're in your twenties, it's often hard to imagine that you won't necessarily always be as fit and healthy as you are now. So, it's important to take the time to plan and be aware of the health problems that dentists tend to face, as dentistry is a physically and mentally challenging profession, which requires flexible hands and fingers, good eyesight and the ability to move freely. It is also important to get to know which organisations can support you now, and throughout your practising life. Having an illness or injury that stops us living our everyday lives is not something that we normally expect to happen, and we certainly shouldn't spend our lives getting up every day expecting the worst! However, careful planning may help you to be better prepared to deal with the effects of a short or long term illness or injury.

## The risks

As well as the more occupational health injuries that dentists are prone to experiencing, such as musculoskeletal problems including back, neck or wrist pain, accidents can affect your ability to see patients too. It only takes a relatively minor injury, such as a fall off your bike or a trip on a night out and you have to take time out, while you wait for your injuries to heal. Add to that the risk of stress-related illnesses and it's clear that any dental professional can be exposed to illness or injury, at any age.

Over the last six years, Dentists' Provident has received, on average, a new claim for musculoskeletal disorders every working day. "In our experience, back, neck, arm and hand pain are the most common musculoskeletal issues for dentists" confirms Bryan Gross, head of claims and underwriting at Dentists' Provident. "We regularly hear accounts of rapid onset back pain – one day you're sitting happily in surgery, caring for a patient; the next day the pain hits and you're barely able to move. One example is of a dentist in his mid-twenties whose back pain left him unable to work for over three months, which you wouldn't expect at that age. We paid him over £10,000 in benefits for this period, which meant that at least he didn't have financial worries, on top of dealing with his back pain."

> 'Another significant reason for dentists being off sick is psychiatric disorders, which accounted for 17% of male and 18% of female claims paid by Dentists' Provident in 2014.'

Another significant reason for dentists being off sick is psychiatric disorders, which accounted for 17% of male and 18% of

female claims paid by Dentists' Provident in 2014. Bryan continues "Psychological disorders, such as anxiety, stress and depression are experienced by dentists of all ages, and are often brought about by their working situation. This can obviously have a significant impact on them and their ability to work, as well as on their personal lives."

## Prevention is better than cure

In Dental Protection's 2014 Annual Review, an observation was made that 'As dental professionals we extol the benefits of preventive dentistry, but we sometimes overlook the preventive steps we can take to try to avoid injuring ourselves.'

Yoga, Pilates, The Alexander Technique and meditation have all been shown to provide physical or mental support and assistance for preventing future health and wellbeing issues. One of Dentists' Provident's members, Kevin Esplin, a senior partner and one of ten specialists at his practice Devonshire House in Cambridge, is a huge supporter of Pilates, The Alexander Technique and Transcendental Meditation. He says "I was already a supporter of Pilates, but after a back operation a few years ago I wanted to try an alternative technique to minimise my back pain, and prevent future problems as well, so I tried The Alexander Technique. I think this and Pilates can greatly help to cope with the challenges that dentistry poses for the spine and I cannot speak more highly of them both."

He continues "I would also recommend Transcendental Meditation to everyone as, in my opinion, it can help dentists manage their stress enormously. I'm very thankful I have been doing it throughout my career, because when the unexpected happens I can take it in my stride more easily and I'm now 62 and still love practising dentistry!"

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## Lifestyle expenses

As well as protecting your physical and mental wellbeing, your finances may need protecting too, which isn't always easy when they are already stretched. With high tuition fees and increasing living expenses, studying to be a dentist involves a hefty financial commitment.

So it could be worth talking to your family, and university, and considering what you would do if an injury or illness forced you to retake a year or, even worse, meant that you were not able to finish your degree. As well as being devastating, it could also put a huge strain on your finances, as you wouldn't have your dental career to support you.

**'So it could be worth talking to your family, and university, and considering what you would do if an injury or illness forced you to retake a year or, even worse, meant that you were not able to finish your degree.'**

In your clinical years, it may also be worthwhile learning about the wide range of financial products which are available to you when you graduate, especially those that can offer you some protection for your lifestyle. Your living expenses are likely to increase after you graduate, so even though dentistry can afford a decent pay and therefore a good standard of living, the more we earn, the more expenses we seem to have! Throughout your career, you may find that your income gets swallowed up in loans, postgraduate courses, exotic holidays, cars, taking on a mortgage or starting a family. So, whether you are planning to be employed in a hospital or work in practice, it is important to protect yourself to make sure that you can still cover your lifestyle expenses, if you can't work because of an illness or injury.

## Protecting yourself

Income protection insurance pays a regular monthly income if you suffer from an illness or injury that prevents you from working, and such claims are more common than you may think. Dentists' Provident is currently paying long term benefits to around 150 of its 13,500 members, some of whom are only in their thirties.

Without some form of protection to support you when you need it, the impact of not being able to study or work, could be devastating.

## Types of products

A quick search on the internet will reveal that there are many financial products to choose from, so you may like to take independent professional advice to find out what would suit you best.

Dentistry is a unique profession and your physical and mental wellbeing is paramount to be able to study, do your job and look after your patients. So, take a tip from your oral health advice and always remember 'prevention is better than cure', or to put it another way 'proactive planning is better than reactive actions' and you could have a happy and healthy career for life.

## *About Dentists' Provident*

*We have supported dentists with income protection insurance in the UK and Ireland for over a hundred years, and are the market leading provider with 13,500 members. As we are a specialist, our members benefit from our in-depth experience of tailoring solutions for every stage of their personal and professional lives. Our members also benefit from our innovative and ethical approach to claims, and personal customer service. We are a mutual organisation so, with no shareholders, we exist solely for the benefit of our members, giving them the opportunity to share in our financial surpluses.*

**Sarah Bradbury**

➤ For further information visit **www.dentistsprovident.co.uk**

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# *BDJ* UPDATE

**Stephen Hancocks** OBE, Editor-in-Chief of the *BDJ* chooses his top picks from the recent crop of articles gracing the pages of this highly-respected journal.


Published twice a month, the *BDJ* is the leading dental journal in the UK and is, in addition, widely read internationally. It is available in hard copy with 20,000 readers an issue (included in BDA Student Membership for 4th and 5th year students) and online at **www.bdj.co.uk** (available to all BDA Student members) where it receives in excess of 100,000 unique visitors a month. It includes news, opinion, research, articles on dental practice and education.

## Periodontal disease – public health matter?

The most recent of our themed *BDJ* issues was published in October 2014 on the subject of periodontology. This issue covered many aspects of periodontal disease, its causes, treatment and associated conditions ahead of a major conference in London in June 2015, EuroPerio (www.epf.org).

One of the articles was an opinion piece entitled *Is periodontal disease a public health problem?*[1], which was also picked up by the general media. The author, Paul Batchelor, argued that clinically defined periodontal disease is highly prevalent, has considerable impacts on individuals and society and is costly to treat: the cost of dental care is the fourth highest of all diseases, consuming between 5 and 10% of all healthcare resources. Changes in the epidemiology of clinically defined periodontal diseases suggest that the prevalence of severe periodontal disease is low and rates of progression of periodontal destruction tend to be relatively slow. Current periodontal care modalities have a remarkably weak evidence base, with considerable resources allocated to fund interventions that include oral-hygiene instruction, scale and polishes through to surgical interventions. Paul proposed that the public health problem lies more in the failure in design of a contract between dental professionals and the state. Such a contract needs to recognise both the wider determinants of disease and the role that dental professionals could play: a contract that concentrated on rewarding outcomes, namely a diminution in treatment need, as opposed to one based simply on the number of interventions, would be a major step forward.

But if we thought this was a new problem another article in the issue[2] brought us an historical perspective in the form of analysis of 303 skulls from a Romano-British burial site in Poundbury, Dorset, which were examined for evidence of dental disease (Fig. 1). The overall prevalence of moderate-to-severe periodontitis was just greater than 5%. The prevalence rate remained nearly constant between ages 20 to 60, after which it rose to around 10%. Caries was seen in around 50% of the cohort, and evidence of pulpal and apical pathology was seen in around 25%. However, the prevalence of moderate-to-severe periodontitis was markedly decreased when compared with the prevalence in modern populations, underlining the potential importance of risk factors such as smoking and diabetes, in determining susceptibility to progressive periodontitis in modern populations.

Which neatly brought the *BDJ* issue to one of those modern lifestyle risk factors: periodontitis and diabetes, which are common, complex, chronic diseases with an established bidirectional relationship.[3] That is, diabetes (particularly if glycaemic control is poor) is associated with an increased prevalence and severity of periodontitis, and severe periodontitis is associated with compromised glycaemic control. Periodontal treatment (conventional non-surgical periodontal therapy) has been associated with improvements in glycaemic control in diabetic patients following periodontal therapy. For these reasons, management of periodontitis in people with diabetes is particularly important. The dental team therefore has an important role to play in the management of people with diabetes. An emerging role for dental professionals is envisaged, in which diabetes-screening tools could be used to identify patients at high risk of diabetes, to enable them to seek further investigation and assessment from medical healthcare providers.

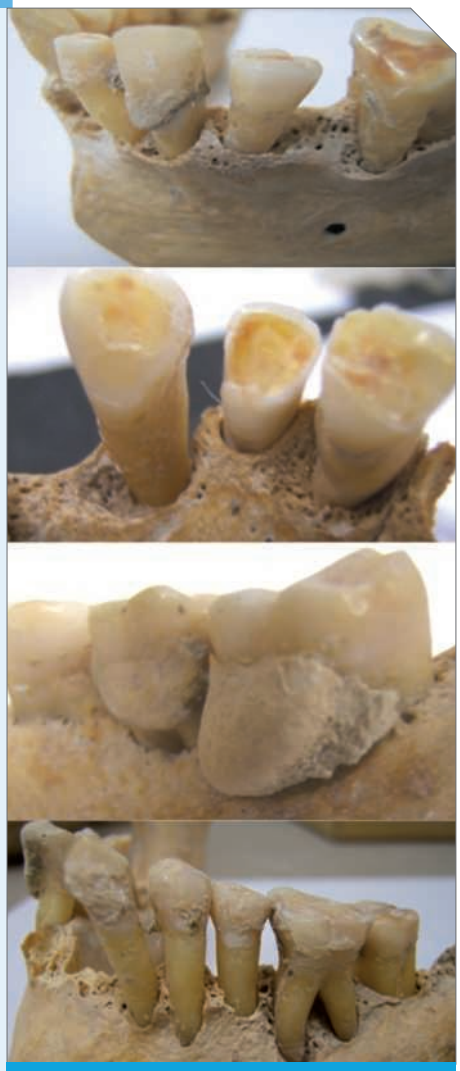


Fig. 1 The prevalence of periodontal disease in a Romano-British population c. 200-400 AD

## Dental photography

Photography has been, and continues to be, an integral component of both clinical practice and dental education and has a large number of potential applications (Table 1), many of which are associated with the potential for litigation. A practice article by Wander and Ireland served to highlight not only the uses, but also the equipment and training needed.[4]

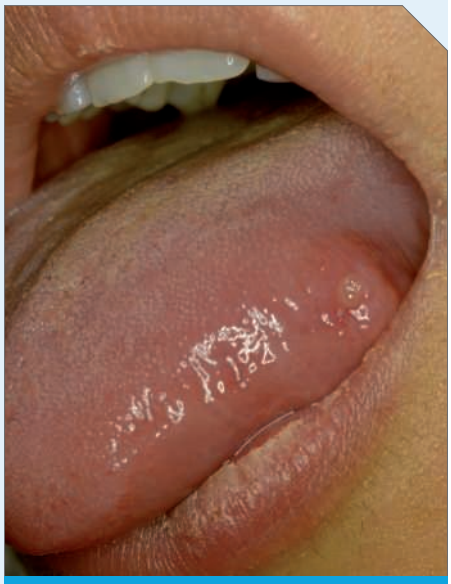
**Table 1 Applications of photography related to litigation and record keeping**

| Applications |
|---|
| The initial patient record |
| As evidence of treatment provided |
| Diagnostic support |
| Legal records and reports |
| Patient communication and education |
| Insurance claims related to treatment |
| Insurance claims related to the practice/clinic |
| Practice publicity |
| Forensic information |
| Audit and research |

It may be tempting to rely on the multitude of cheap pocket cameras and mobile phones, the quality of which are constantly improving, however these cameras lack the quality and versatility needed for clinical photography. A Macro lens with a focal length of 90mm is ideal for taking undistorted portrait or full face views as well as profile views. A Ring Flash with TTL (Through the Lens) metering compatible with the camera body is essential to avoid the creation of unwanted shadows. An important advantage of this lens-flash combination is that relatively inaccessible objects deep in the oral cavity can be evenly lit, even when the ring flash is partially obscured by the lips or cheeks, and correctly exposed images in difficult areas are still produced. Ring flashes are widely used in photographing body cavities (such as in forensic work), and therefore appropriate for use in intra-oral photography. The eyepiece of a single-lens reflex camera's viewfinder can be adjusted to suit the individual's visual requirements. Photographs are framed in the viewfinder as opposed to compact cameras and mobile phones, where the LED screen at the back of the camera is usually used.

The aperture can be controlled and changed to maximise the depth of field, (depth of focus or the range of sharp focus) increasing the image area that appears sharply in focus in the final picture. Apertures can be selected giving an excellent depth of field with, for example, all the teeth in focus from incisors to molars. Electronic through-the-lens (TTL) flash metering is available which enables a perfect exposure to be obtained without adjusting the aperture every time a different close up magnification view is chosen. Once set up correctly, the system will give consistent and repeatable results in exposure, magnification and colour rendition so before-and-after photographs can be accurately compared. This is particularly important when trying to compare the colour change before and after treatment in terms of hue, value, shade or saturation with restorations such as crowns or veneers.

When photographs are taken using a standardised method, comparisons can be drawn throughout the treatment detailing the specific changes that have occurred during the intervening period particularly with reference to images of tissues taken before and after treatment. This standardisation is important when using images to support clinical evidence.



Oral mucosal lesion. Ulcer on left side of tongue. Approximately 3 mm diameter with red border. Has been present for three days. Traumatic in origin; produced in response to biting

## Evidence based dentistry

Another publication brought to the profession and literature by the *BDJ* is the quarterly journal *Evidence Based Dentistry (EBD)*. This is available as a stand-alone journal but is also bound in to the *BDJ* (Fig. 2).

The aim of *EBD* is to alert clinicians to important advances in the practice of dentistry and its specialist areas by selecting from the biomedical literature those originals and review articles whose results are most likely to be true and useful.

The articles are then summarised in value-added abstracts and commented on by experts.

For example, Volume 15 N3, published in the *BDJ* issue of 24 October 2014 included the following content:

- Insufficient evidence to determine the effects of routine scale and polish
- Moderate quality evidence finds statistical benefit in oral health for powered over manual toothbrushes
- Review suggests that cleft lip and palate patients have more caries
- Trial shows partial caries removal is an effective technique in primary molars.


Fig. 2 Cover of *EBD* Vol 15 No 3

## e-cigarettes and patients

There has been a lot of discussion in the media and publicity about e-cigarettes but what should we tell our patients? We published an article with this question to try and help guide dental professionals (Fig. 3).[5]

The conclusion reached was that while further research is needed on the safety, quality and effectiveness of e-cigarettes, it is also needed on their efficacy as a smoking-cessation and harm-reduction tool. With the rapid expansion of this market and the availability of new and changing products, smokers, former smokers and those who have never smoked are already deciding the purpose of e-cigarettes.

Delays in regulation and legislation may potentially allow the markets to determine the course of their use. Meanwhile, as health professionals, we need to be able to answer the questions raised by patients about e-cigarettes and keep abreast of this rapidly developing market.

Fig. 3 Three types of e-cigarettes: disposable e-cigarette; rechargeable cartridge e-cigarette; and rechargeable liquid refillable e-cigarette, photographed by PSP Worsley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**Stephen Hancocks** ■

## Cover images



Finally, we always attempt to make the *BDJ* cover images relevant and topical. Consequently, the cover images in volume 217 (July-December 2014) were designed to commemorate the centenary of the start of the Great War. Because the material available on which to base images was very variable, some photographs, some artifacts etc., we decided that for consistency we would commission an artist to provide illustrations and chose Philip Bannister whose work has graced the series of 12 issues.

Dentistry and oral surgery came to the fore in World War I and significant advances in dental treatment and oral surgery were made to cope with horrendous facial injuries and the sheer volume of troops. The cover shown here (Figure 4), is an illustration of a photograph taken from a personal album compiled by Sister Mary Agar who worked in the Canadian Ward at the Queen's Hospital in Sidcup during the Great War. The patients, dressed in their hospital uniforms, are shown in various stages of their reconstructive procedures. The photograph is part of the Antony Wallace Archive of the British Association of Plastic, Reconstructive and Aesthetic Surgeons (BAPRAS), housed at the Hunterian Museum. Visits by appointment only, please contact secretariat@bapras.org.uk.

Fig. 4 *BDJ* Vol 217, No. 8 cover image

# *BDJ IN PRACTICE* UPDATE

## Selected by **Graeme Jackson**, *BDJ In Practice* editor


*BDJ In Practice* is the BDA's membership magazine and covers a range of business-focused topics. Formerly known as *BDA News*, the articles below featured in a recent issue. While they are aimed at established dentists, they are also relevant to young dentists preparing for their future careers.

## Social media turn offs

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Research has shown that the best way to get people to engage on social media is through offers and discounts.

It found that 52% of people who use social media cite these as a key factor in their engagement with brands. Interesting content (cited by 42% of respondents) and a quick response to enquiries (again cited by 42%) were also important factors in engagement.

When asked what they didn't like their brands doing on social media, too much spam (46%), slow response to enquiries (40%) and irrelevant posts (38%) were the main complaints.

The survey of 2000 people, conducted by One Poll and commissioned by The Wee Agency, also identified significant differences between what business2business and business2consumer buyers want from a Website.

Consumers' main priority is that the site is fast to load – 58% said a slow site would annoy them. But, in a business context, lack of information was the main turnoff – 52% people said this is annoying.

'The growth of Internet sales channels and globalisation of dental manufacturing has opened a door for unscrupulous operators to sell poor quality, substandard or even counterfeit or illegal products.'

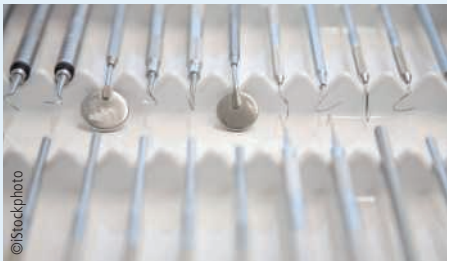
## Initiative to battle fake devices

Dental organisations are banding together to help dentists avoid being conned by fake and substandard dental instruments and devices. The *Counterfeit and substandard Instruments and Devices Initiative* (CsIDI), launched by the British Dental Industry Association (BDIA), is an industry-wide activity with three main aims.

It will promote awareness of the dangers of poor quality, counterfeit and illegal dental instruments and devices; provide a quick and simple way for reporting these to the relevant bodies; and encourage dentists to buy only from reputable manufacturers and suppliers, such as BDIA-member companies.

All reporting can be done through a simple, dedicated page on the BDIA Website – www.bdia.org.uk

The growth of Internet sales channels and globalisation of dental manufacturing has opened a door for unscrupulous operators to sell poor quality, substandard or even counterfeit or illegal products. So, it is vitally important that dentists buy from sources that ensure quality and efficacy, the BDIA has warned. The CsIDI has the backing of the Medicines and Healthcare products Regulatory Agency and the British Dental Association.



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## Text relay goes mobile

People with hearing or speech impairments can now hold faster, more fluent telephone conversations thanks to a next-generation, text-relay service.

The service has been developed by BT, but all landline and mobile-telephone providers are making it available to their customers.

A relay assistant acts as an intermediary to convert speech to text, and *vice versa*, for the two people in conversation.

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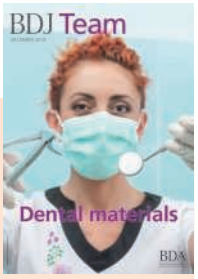
Users can now link their landline and/or mobile number to a TextNumber – a standard 11-digit phone number that will bring the relay service into the call automatically. This means that people calling hearing- and speech-impaired users who use TextNumbers no longer have to dial the 18002 prefix before their number, nor do they need to know about the text relay service in advance.

The new service allows for parallel speech, hearing and text, with the ability to interject for the first time, and without the need to say or type "go ahead" after each part of a conversation.

**Graeme Jackson** ■

# *BDJ TEAM* UPDATE

By **Kate Quinlan**, *BDJ Team* editor




*BDJ Team* is a brand new addition to the *BDJ* portfolio of publications and like its predecessor, *Vital*, is aimed at the whole dental team. *BDJ Team* is published online only and in 2015 will be published every month except for August and December.

To fulfil its goal of informing, educating and entertaining dental care professionals (DCPs), *BDJ Team* also provides one hour of verifiable continuing professional development (CPD) in each issue.

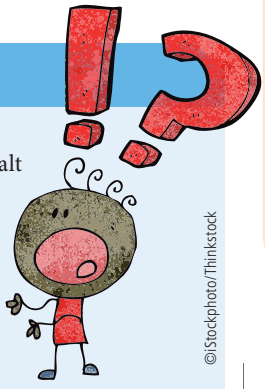
## Dental complaints

The August 2014 issue of *BDJ Team* provided an update on the important issue of dental complaints. Handling dental complaints is a topic that the General Dental Council (GDC) recommends all dental professionals should keep up to date with and include in their CPD.

In *Local resolution is an essential part of complaints*, Hazel Adams, Head of the Dental Complaints Service (DCS), explained what the DCS is and what it does.

The DCS helps patients and dental professionals put things right when problems with private dental treatment arise, and is a free and impartial service.

From June 2013 to June 2014, the DCS dealt with more than 8500 calls, mostly about: dentures, crowns, fillings, root canal treatments, bridges, pain, service and cost.



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The article in *BDJ Team* also looked at why the number of complaints within dentistry is increasing, and provided advice for dental professionals.

The full article is available at: http://www.nature.com/articles/bdjteam201489.

## Interview with new BADT president

In the November 2014 issue of *BDJ Team*, editor Kate Quinlan interviewed Fiona Sandom, the new President of the British Association of Dental Therapists (BADT). Fiona is a dental therapist with North Wales Community Dental Services, a postgraduate tutor at Cardiff University, and a GDC Quality Assurance Inspector. Here is an excerpt from the interview with Fiona.

**In 1997 [while working as a dental hygienist] I heard about the conversion course for dental therapy and felt that this was an area I would like to explore.** My son was two and I was only working part time. After some preliminary research there were murmurs that dental therapists would be able to work in practice in the near future. Anglesey at that time had a shortage of dentists, especially in the NHS, and I felt that if I could take some of the workload from the dentists this would increase patient access to care, as well as increase the variety of treatments that I was able to deliver.

**It wasn't until 2002 that the restrictions were lifted and dental therapists were allowed to work in all areas of dentistry.** I received my Diploma in Dental Therapy from Liverpool in 1999. I was fortunate to secure a therapy post in the North Wales Community Dental Service, for one day a week. This helped me greatly as I was supported by a dental officer and an experienced dental nurse and ensured that I didn't deskill until therapists were able to work in all areas of dentistry.

I am aware that this is not the case everywhere, especially in areas close to dental hospitals. I understand that the new NHS contracts in England and Wales promise to involve a greater use of skill mix and an increased advantage to employing dental therapists.

**As BADT president, I like to help address the issues around direct access.** The GDC has lifted the restrictions and allows us to see and treat a patient without first seeing a dentist. However, there are legislative issues that are beyond the GDC, for example NHS regulations and prescribing rights. I am aware that the time frames to resolving these issues are long; I want to work with all four chief dental officers (CDOs) to understand these issues and work at resolving them.

## Dental nurses' career expectations

In a piece of original, peer-reviewed research, Ms Shahinaz Sembawa, a former MSc student at King's College London Dental Institute, explored the career motivation, expectations and influences of trainee dental nurses. This was published in *BDJ Team* in September 2014.

The qualitative research involved focus groups of dental-nursing students across training institutions serving hospital and dental services. The study discovered that dental-nurse students are motivated by 'features of the job', interest in the dental field, professional factors, healthcare and lifestyle factors, and the influence of advisors.

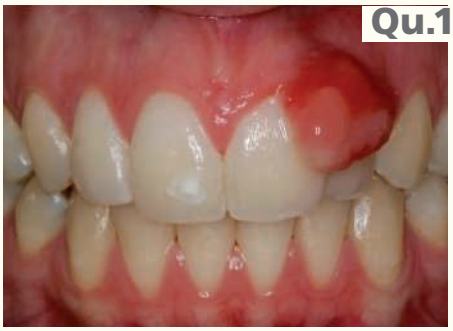
The article concluded that student dental nurses have similar motivation, expectation and influence to other members of the dental team. There was a strong interest among participants in careers in professional development within dentistry, including dental hygiene and therapy.


Fig. 1 Motivation of dental nurses in training for a selection of careers in dentistry

**Kate Quinlan** ■

## Question 1

*You are a dentist in general practice and a 30-year-old female presents with the gingival appearance below. Take a brief history and explain to the patient what is the most likely diagnosis and treatment of the lesion.*




# REVISION

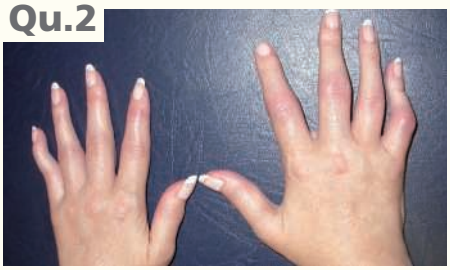
Test your knowledge with the following questions from **PasTest**

## Question 2

A. Describe the clinical signs seen in this photograph.

B. What medical condition does the patient have?

C. How may this condition influence dental treatment and health?




## Question 1
### ANSWER

*1. Introduce yourself politely to the patient.*

*2. Check their medical history including smoking, alcohol and pregnancy status, and medication history.*

*3. Ask questions regarding the lesion/ lump:*

- When and how did you first notice it?
- Has it changed?
- What symptoms does it cause, e.g pain?
- Does it ever disappear? If so what makes it come back?
- Ever had similar lesions or have similar lesions elsewhere?
- Any associated features, e.g bleeding?

*4. Explain to the patient that it is a discrete swelling on the gum, which may be caused by hormonal changes. If the patient has told you she is pregnant, explain that it is likely to be a pregnancy epulis (a localised gingival lump usually located on the labial interdental papilla). If the patient has mentioned she is, or has been systemically unwell, then refer her to her GP.*

*5. What treatment would you advise?*

Explain that conservative treatment (oral hygiene and scaling) is indicated unless an epulis interferes with occlusion or is unsightly – in which case it can be surgically removed and sent for confirmatory histology.

In this case, oral hygiene and scaling is the treatment of choice.

Explain that poor oral hygiene predisposes to exacerbation of inflammation as a result of increased progesterogen levels. This typically occurs in the second month of pregnancy and reaches a peak at around the eighth month and may revert to the previous level of gingival health after delivery of the baby.

NB: Differential diagnosis of discrete gingival lumps includes:

- Giant cell tumour
- Exostosis
- Pyogenic granuloma
- Cyst
- Neoplasm.

The history and clinical findings will help in the differential diagnosis.

## Question 2
### ANSWER

*A) The clinical signs seen in the photograph are:*

- Fingers with swan neck deformity (hyperextended proximal interphalangeal [PIP] joints and flexed distal interphalangeal [DIP] joints).
- Boutonniére's deformity (flexed PIP joints, extended metacarpophalangeal [MCP] joints and hyperextended DIP joints).
- Other features associated with rheumatoid arthritis but not seen on this picture are thumbs with 'Z' deformities and subluxation of the MCP joints and wrists with ulnar deviation.

*B. Rheumatoid arthritis.*

*C.*

- The patient may be on non-steroidal anti-inflammatory drugs (NSAIDs), so you do not want to prescribe further NSAIDs for dental pain.
- The patient may be on steroids. Consider the need for prophylaxis in those with actual or potential adrenocortical suppression. Dose for prophylaxis is 100 mg hydrocortisone (as sodium succinate) intramuscularly, 30 minutes pre-operatively.
- The patient may have rheumatoid arthritis in other joints, e.g temporomandibular joints.
- The patient may have other problems, e.g the rheumatoid arthritis may be part of a connective tissue disorder in Sjögren syndrome.
- The patient may have difficulty with toothbrushing due to decreased manual dexterity.
- If the patient is to have a general anaesthetic there is a risk of atlanto-axial joint subluxiation when extending the neck.

## Question 3

*A 78-year-old lady who smokes presents with a left submandibular gland swelling. On examination she has a scar in the right submandibular region, which she says was from an operation to remove a gland and the result was a benign tumour. What is the diagnosis?*

A. Mucoepidermoid carcinoma

B. Pleomorphic adenoma

C. Mealtime

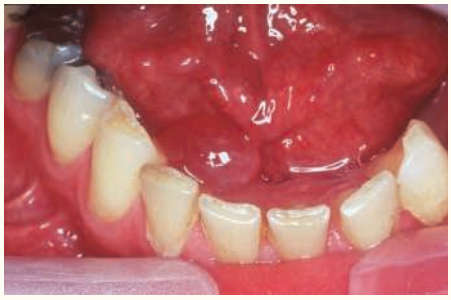
D. Adenoid cystic carcinoma

E. Warthin's tumour

## Question 3
### ANSWER

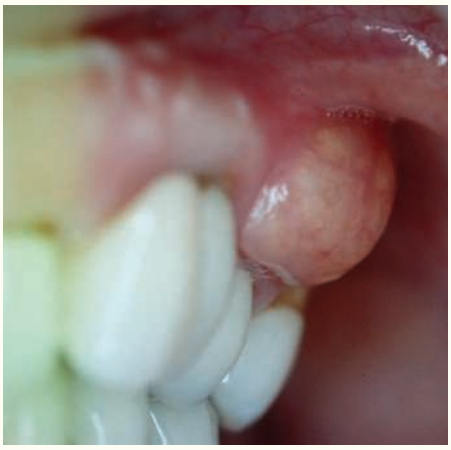
*E. Warthin's tumour*

Warthin's tumour (adenolymphoma) is a benign tumour that is more common in women and smokers. They are bilateral in 15% of cases, however the masses normally present at different times.



**Confident you know all there is to know about unilateral lesions? Keen to check the definition of an inflammatory odontogenic cyst? Test yourself in this and every issue of *BDJ Student* to ensure you keep on top of your revision.**





## Question 4

*Which of the following spreading odontogenic infections can present with minimal swelling and absolute trismus?*

A. Sublingual

B. Parapharyngeal

C. Submandibular

D. Submaseteric

E. Buccal

## Question 4
### ANSWER

*D. Submaseteric*

The masseter is an extremely powerful muscle and irritation due to underlying abscess leads to irritation, spasm and therefore trismus.

# HOW TO: GIVE EFFECTIVE ORAL-HYGIENE ADVICE

## In the second instalment of her series on periodontal disease, **Reena Wadia** discusses how to give oral hygiene advice

Providing oral-hygiene advice is one of the first skills you learn at dental school. It is also undoubtedly one of the most important skills to master. Delivering effective oral-hygiene instructions to your patients will help prevent future disease and optimise the success of any treatment.

Here are five tips that will make the process of providing oral-hygiene instructions more efficient and effective.

1 Ensure you orientate your patient before you start discussing the various toothbrush angulations and interdental hygiene techniques! Understandably, many patients are ignorant of the oral anatomy and have an inadequate spatial sense, so begin by introducing the basic anatomy of the oral tissues. The teeth and gingivae can be visualised using a hand mirror or perhaps even an intra-oral camera for more detail. At this point, it is also important briefly to mention the aetiology of periodontal disease and caries to ensure they are aware of the importance of good oral hygiene.

### *Dr Reena Wadia CV*

| | |
|---|---|
| **1987** | Born in London |
| **2011** | Graduated from Barts and The London |
| **2011-2012** | **DF1** at MK Vasant & Associates |
| **2012-2013** | **DF2** in Restorative Dentistry and Oral Surgery at Guy's Hospital |
| **2013-2014** | ***Associate*** at Pure Periodontics |
| **Present** | ***StR in Periodontology*** at Guy's Hospital |
| | ***Associate*** at Harley Street Dental Group and Woodford Dental Care |

**Other positions**

***Clinical Tutor*** at Barts & The London

***BDA Committee Member, Croydon***

***FGDP Board Member, Central London***

> **'Taking a photo for the patient on their camera phone is a great idea as it allows the patient to refer to the photo between visits.'**

2 Always disclose plaque! Using a plaque-disclosing tablet or solution can be incredibly powerful in providing a clear visual illustration to the patient. This can help when giving tailored oral-hygiene instructions because you can easily show the patient the areas they are missing.

Taking a photo for the patient on their camera phone is a great idea because it allows the patient to refer to the photo between visits. By calculating a plaque score, you can also keep an objective measure of the patient's plaque level, which may help to improve and maintain patient motivation.

3 It is important to remind your patients to bring their oral-hygiene aids to all appropriate appointments. This allows the patient to demonstrate their current oral-hygiene regime. Having the chance to adapt the patient's technique and show them intra-orally is far more effective than using a model.

4 The most commonly missed areas during brushing are the lingual and palatal surfaces. If this is the case, it might be an idea to advise the patient to clean these areas first. If you can see the patient is being far-too aggressive when brushing, then perhaps advise a pen-grip to hold the toothbrush and emphasise brushing using the wrist rather than the elbow or shoulder.

5 Make sure you keep instructions simple to maximise the chances of the patient remembering your advice and complying. Regular reinforcement is also essential.

As a student, you have the luxury of long appointments, so make the most of this time to become an expert at giving effective oral-hygiene instructions! Finally, always remember that you should give advice according to what is most suitable for your patient, their oral condition and their circumstances.

**Reena Wadia** ■

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# EXTRACTION OF TEETH FOR CULTURAL REASONS

By R Panju[1] and K Fox[2]

IN BRIEF

- Highlights the extraction of teeth for cultural reasons
- Explores the historical context of such extractions
- Informs readers of current practice of ritual extraction throughout the world

*Throughout history, the ritual extraction of teeth has been identified in many cultures over all five continents. Reasons documented for these extractions include initiation, marriage, death, social status and tribal identification. It has been shown that in all cases, the extracted teeth appear to have been in the anterior sextants. This article discusses the historical practice of ritual extraction and reports on how and why this is still performed today.*

## Introduction

The ritual removal of healthy teeth has been practised in several regions of the world since prehistoric times. There are ethnographic and skeletal records of ritual extractions in Hawaii, Japan, Italy, South Africa, Thailand, Siberia, Alaska, Sudan, Kenya, Uganda, Australia, the Arctic region and Britain. Although rare, ritual extraction continues to be practised in a few parts of Africa today.

The reasons for such extractions, and rituals like filing or staining the teeth, have been summarised by Frazer and Campbell.[5] These include rites of passage such as initiation, engagement, marriage or loss of spouse. In addition, it has been carried out for other reasons, such as: ornamentation, mourning, tribal identification, to enhance safety or welfare of an individual or their tribe, to start or stop the rain and to ensure hunting success. In Britain, avoiding the cost of future dental treatment was the main reason for extracting teeth as a wedding present.

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[2]Senior Clinical Lecturer in Restorative Dentistry, Liverpool University Dental Hospital, Pembroke Place, Liverpool, L3 5PS

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Maasai warriors stand in circle to sing to celebrate passages in life such as circumcision and marriage Kenya

The reasons for ritual tooth extraction are relatively easy to pinpoint in cultures where it is currently practised or in countries like Britain where the practice has only ceased in the past 50 years. However, explanations are slightly more complicated to come by when referring to the practice in Paleolithic and Prehistoric times, as evidence from these periods can be misleading. For example, missing teeth seen on skeletons can also be attributed to pathology of the dentition or periodontal tissues (especially if there is evidence of infection in the alveolar bone), trauma, exposure of the pulp owing to extreme wear either by a gritty diet or by using the teeth as a tool. Congenital absence or impaction could also be a reason for the missing teeth.

Most researchers identify the practice of ritual extraction of teeth, also known as ablation, if there are repetitive symmetrical patterns of tooth loss in individuals of all ages.

## Tooth extraction ritual in the Luo tribe

The Luo tribe is an old Nilotic tribe who moved up the River Nile to settle in East Africa around Lake Victoria. In Kenya, they live mainly in Kisumu, which is in the west of Kenya, bordering Uganda and north-east Tanzania.

Ritual tooth extraction has been practised for many centuries among the Luo tribe of Kenya, possibly even before they moved to East Africa. The teeth typically extracted are the lower anteriors, canine to canine.[2] Extractions are usually performed by the elder of the tribe or midwives.[2] There has been some debate as to at what age this occurs. Inoue[2] reports that the typical age of extraction is six years old. However, his paper refers to more than one tribe


Masai Youth at Tsavo National Park in Kenya

and therefore this may not be the case for the Luos. At the age of six, not all lower anteriors will have erupted and thus it would not have been possible to extract these teeth for a child of that age. However, in the same paper, Inoue cites Harunari 1982, who reported that the ritual could occur at any time from adolescence to adulthood. Other reports have stated that the teeth are extracted around puberty or early adolescence.[2] However, six years old would be a good age for tribes to extract lower central incisors as at this age root formation is incomplete and the teeth are easier to extract.[2]

It has been stated that teeth were extracted traumatically by knocking them out.[2] However, Inoue reports that in Kenya an instrument resembling a dental elevator is placed in between the teeth and moved "jimmyingly and joltingly" to loosen the teeth.[2]

**'For approximately the first eight decades of the twentieth century, it was common for women in Britain to have all their teeth extracted at a dentist and dentures fitted.'**

There has been a misconception that this ritual replaced the ritual of circumcision among the Luos; however, that is not the case.[1] Circumcision is an event that occurs on a grander scale with ceremonies involving the entire tribe. In contrast, the extraction of teeth is more of a custom. It is not a rite as there is no ceremony involving the entire community when an individual has their teeth extracted.[1, 2]

The reason for tooth extraction in the Luo community is threefold.[1] Firstly, it offers a convenient way of feeding during tetanus attacks of the muscles of the jaw.[1] Secondly, during this attack, the space created offers a convenient

way of feeding medicinal herbs.[1] Thirdly, it acts as an identification mark as the number of teeth the Luos remove is different from the neighbouring Kipsigis, Teso, and Maasai tribes.[1]

The trend of tooth extraction among the Luos is declining, possibly because of the country becoming more developed and the movement of people from rural areas to cities. There is a decreasing frequency of tooth ablation in the younger generations than was the case in the elderly.[2] It is also practised less in major cities than in smaller towns and villages.[2] It is believed that the practice is in its last stages and may cease to exist in the near future.[2]

## Tooth extraction in the Maasai

The Maasai, like the Luo, are Nilotic and followed the River Nile and entered Kenya through the South of Sudan. Most Maasai are now settled in Kenya and Tanzania near the safari game drives. Their location, their customs and traditional dress make them one of Africa's famous ethnic groups.

The Maasai migrate to better pastures for their cattle. This makes it difficult to access health care and education facilities in Kenya. However, oral examinations were carried out in the 1990s by The Nomadic Health Unit of African Medical and Research Foundation (AMREF).[3]

Ritual extraction of teeth in the Maasai is done to different teeth and for slightly different reasons than for the Luo tribe. The teeth extracted are the deciduous and permanent lower centrals and the deciduous canine tooth buds.[3] The extraction of the deciduous canine tooth buds is a more recent practice that seems to have originated in neighbouring Tanzania, Uganda and Sudan.[3] According to the Maasai, the tooth buds are removed because they cause diarrhoea, vomiting, fever and other febrile illnesses.[3] In a study carried out in Uganda where this myth originated, it was established that malaria and gastro-enteritis were the most frequently reported causes of fever and diarrhoea; fever and diarrhoea were in turn the reason for this practice (known as 'ebino' in Uganda which means 'false teeth').[4] This belief is so widely held that people believe that unless the tooth buds are removed, a child will die despite conventional medical treatment at a hospital or a dispensary.[4] The belief stems from the observation that the bovine calf does not have deciduous canines and therefore did not suffer from the above mentioned illnesses.[4]

The tooth buds are surgically removed by a woman for a small fee.[3] She uses a non-sterile knife and removes the tooth bud without anaesthesia.[3] Post-operatively, a salty or sugary solution is applied to the sockets to help stop bleeding and prevent infection.[3] The extraction of the tooth bud usually occurs at the ages of six months to two years; mostly within the first year.[3] At this age, since the calcification of the crown is incomplete, the tooth looks like a maggot (or what the Maasai call a 'dudu') and does therefore fit in quite well with their belief.[3] In a study carried out in 1994, 84% of babies between the ages of six months and two years had undergone the removal of at least one lower deciduous canine tooth bud.[3]

There are many post-operative complications resulting from the extractions. The bleeding, swelling and resulting infection can be severe and sometimes fatal if they lead to anaemia or septicaemia.[4] Children may be unwell even before the operation (as the operation is a result of illnesses). Future problems include damage to the unerupted permanent canine or a malpositioned or hypoplastic tooth.[3]

The extraction of the deciduous and permanent lower centrals is an age-old custom for the Maasai. The teeth are removed as soon as they emerge in the mouth.[3] The practice may have therapeutic gain and is associated with initiation ceremonies and tribal identity.[3] This ritual still exists in the Maasai population today.

## Ritual tooth extraction in Thailand

The analysis of ritual tooth ablation in Thailand is more complex because the practice occurred in prehistoric times. A study in 1996 involved excavating an undisturbed burial site in Thailand that was dated to 4000-3500 BC.[5] Since this was a Neolithic era, it is fairly difficult to establish the reason for the ritual, why it stopped, which teeth were extracted as part of the ritual, and which were absent for other reasons. Some of the individuals had unusual wear patterns and it is believed that they may have used the teeth as tools. [5] Extreme tooth wear may have been a cause of pathological tooth loss making the study somewhat unhelpful.[5]

From artefacts found with the subjects, it is understood that the people were potters, producing ceramics of high quality.[5] Other discoveries from the excavation site were ornaments of bone and shell, stone tools and fish hooks found in graves of both sexes.[5] The study considered whether or not the ritual was different depending on social status (evident from the artefacts buried with the individual), age and sex.[5]

There was a difference in patterns of symmetry of tooth extractions between early and late burials.[5] Earlier burials seemed to have extractions of mainly lateral maxillary incisors followed by mandibular central incisors.[5] In individuals that were buried later, all cases had missing maxillary central incisors followed by a number with missing mandibular incisors and a few cases of missing upper laterals.[5] Skeletal patterns of pre-pubertal individuals in later burials showed that the ritual was carried out at a fairly young age.[5]

There were no differences between sexes in the teeth extracted in the earlier burials.[5] In the later burials, the removal of mandibular incisors was more common in females than in males, whereas missing maxillary incisors were more commonly found in the male burials.[5]

It is difficult to make strong conclusions on these studies, as the sample size was quite small. There were 150 burials in Khok Phanom Di and five in Ban Kao and included men, women and children.[5] However, recurring patterns of similar missing teeth in these individuals tell us that some form of ritual tooth removal did take place.

## Extraction of healthy teeth in the female population of Britain

For approximately the first eight decades of the twentieth century, it was common for women in Britain to have all their teeth extracted by a dentist and have dentures fitted.[6] This was often done either as a twentyfirst-birthday present or a pre-wedding gift.[6,7]

Having all these teeth extracted was seen to be far more preferable than enduring the pain and appearance of a mouth full of decayed teeth.[6] Dentures looked better than natural teeth and they were thought to reduce the cost of future dental treatment, which was expensive. In 1975, Taylor[7] stated that after the introduction of sweets in the 1950s, total extraction of decayed stumps by the age of four became the norm. Total extraction of permanent teeth around puberty was not uncommon either.[7] There were still reported cases of full dentures being given as birthday presents as late as 1975 in North Wales.[7] However, as the general public became

more aware of oral health, this practice ceased. In addition, fluoridated toothpastes and an improved diet improved the dental health of the nation. According to the Adult Dental Health Surveys of 1968 and 2009, the number of edentulous people has now reduced considerably from over 35 per cent in 1968 to around six per cent in 2009.



Masai Warriors at Tsavo National Park

## Observation of the ritual in the Luo community

Currently, very few Luos ritually extract their teeth and much less so in the urban areas. Of the people that still practise the ritual, most have the teeth extracted professionally at the dental department of a hospital, while others have the procedure performed by a village elder.

**'Dentists in East Africa are aware of the tradition and carry out the extraction of healthy teeth if requested.'**

It is difficult to observe the ritual in a Luo village, as it happens quite rarely and in fairly remote places. However, it is possible to observe a number of ritual extractions in a hospital setting with varying levels of anaesthesia.

I observed such extractions on a visit to a Luo community. A few of the individuals who came for ritual extraction were aware of local anaesthesia but insisted on having all six teeth (lower canine to canine) extracted without it. Others were unaware of the numbing effects of local anaesthesia and assumed that the pain from injecting the local was the pain normally felt during these extractions. The hospital would charge the equivalent of £15 for the extractions, which would be about a month's income for some individuals.

On the day following the extractions, a celebratory family dinner was held at the house of the patient who had had their teeth removed. At this dinner it is customary to slaughter a goat. The individual who had his teeth extracted on this occasion was a 17-year-old boy. He was proud of himself for undergoing the extractions and mentioned the reasons for why his community practised the ritual. He stated that when an individual has their teeth extracted, they are given status in the community, which is more influential than the importance provided by wealth. Additionally, extractions were seen to be aesthetically pleasing and men who did not have teeth extracted were not as handsome as those without the lower six teeth. The extractions were also seen as a sign of maturity, signifying that an individual is now ready for marriage.

The ritual, for those who still practise it, is taken very seriously among the Luo. Families save up for approximately six months to be able to afford the extractions and the subsequent sacrificial goat.

## Conclusion

Very few communities around the world, other than the Maasai, still practise the ritual extraction of teeth. Dentists in East Africa are aware of the tradition and carry out the extraction of healthy teeth if requested. They believe that people would extract those teeth regardless of whether the dentist will agree to do it or not and therefore prefer to do it themselves using anaesthesia and safe techniques. They are then in a position to control any post-operative complications that may arise.

In the Western world it is useful to be aware of the ritual especially if GDPs join charitable organisations, such as Bridge2Aid. When providing dental care in East Africa, dentists may be presented with patients who request (or have undergone) such extractions. It should also be noted that the Decayed Missing Filled Index (DMF) in this region may be skewed because of these rituals.

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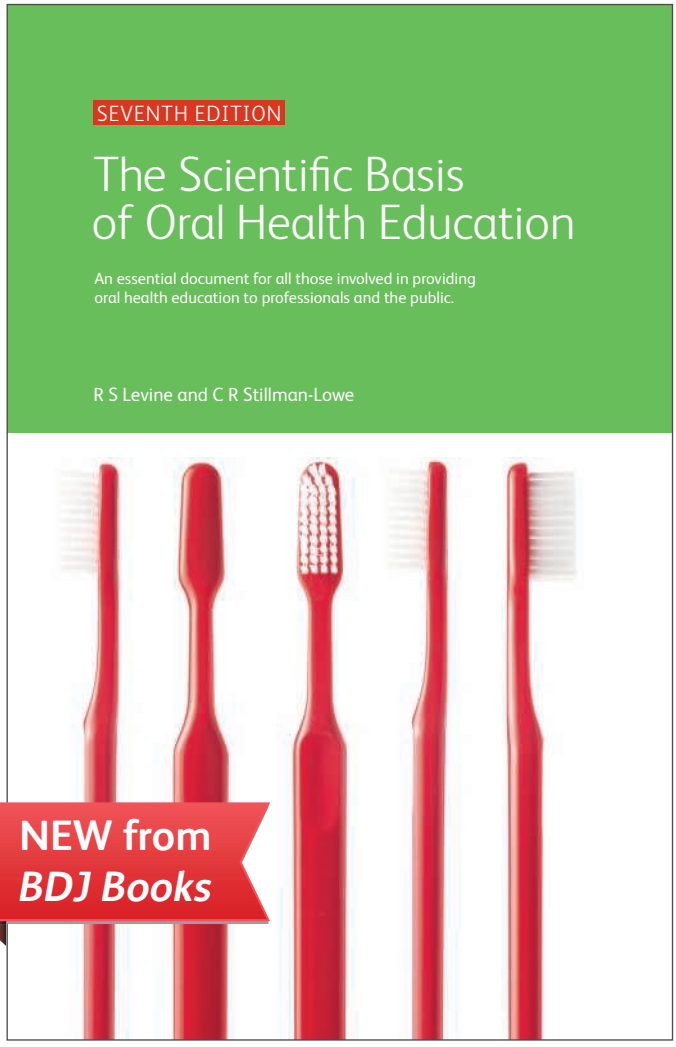


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