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SHAMEFUL CULTURE OF BULLYING

Once upon a time bullying was a word confined to childhood. A term that conjured up images of the playground and telling yourself that 'sticks and stones may break my bones, but words will never hurt me'. Children who were bullied were told to ignore it, be tougher.

It also used to be that the image of the brusque, aggressive authority figure was well known and accepted, especially within healthcare, think Sir Lancelot Spratt in the 'Doctor' movies. Their colleagues were meant to ignore it, be tougher. But the truth is that bullying has never been confined to the playground; the real Sir Lancelot Spratts weren't just pompous and bad-tempered, they were the accepted face of bullying in the workplace.

Today, as in the past, bullying and undermining behaviour permeates our society and, for those on the other end of it, turning the other cheek is easier said than done. The saving grace is that at least society is recognising this, shining a light on it, understanding the impact, and trying to do something about it.

There is a large amount of evidence as to the prevalence and impact of bullying, undermining and harassment within healthcare, and there have been several high-profile campaigns encouraging healthcare professionals, representative groups and the NHS to work together to stamp out these damaging behaviours.

Although these campaigns have touched nearly every profession within healthcare, and some have even had a token nod toward dentistry, as of yet, there has been nothing which grasps the nettle for dental professionals.

Are we to understand from this, therefore, that it isn't a problem in dentistry? Evidence and anecdote would suggest otherwise, and



in this edition you can read about the issue and the work that is being done to define and address it.

But I want to talk about something else. I want to talk about what it is really like to be on the other end of a bully. Because of the lingering association with childhood and childishness, we still tend to trivialise bullying and the damage that bullies do, treating the victims as if they are somehow slightly pathetic, and perhaps just not tough enough to cut it.

Even with so much more understanding of the issues, adults who are bullied can be reluctant to report it because there remains a sense that it is somehow shameful, but there is nothing shameful or trivial about being a victim or about the consequences of bullying and undermining.

Imagine feeling constantly mentally and emotionally attacked in your workplace. Imagine taking that home with you every night, lying awake, replaying what happened and suffering acute anxiety about what may happen the next day.

Imagine becoming so riven with self-doubt, constantly questioning whether you are good enough, whether you can still do your job, whether you should just give up. Imagine it becoming so bad you need medication to cope.

Perhaps you don't need to imagine and have gone through some or all of this, because none of this is fictional.

Bullying is not trivial; it can wreak havoc on individuals, teams, and organisations. To have a team member suffering in this way can severely impact the team itself, rendering it ineffective with both the victim, and their colleagues who witness the bullying and undermining, afraid to speak up, afraid to tackle the bully.

Imagine if that bully makes a mistake





which could harm a patient, but the team around them is too scared to speak up and stop it.

Too often within the institutions and organisations associated with healthcare, bullying cultures have been allowed to fester. Bullies have been downplayed as being assertive or demanding and have escaped any consequences for their actions. To truly tackle it we must admit that it is there and this, at least, is now happening.

With widening acknowledgement, however, has come a more recent trend to teach resilience, both at school and in the workplace as a way to deal with bullying. From primary school, children are widely taught about how to be more resilient, and resilience training is routinely offered to adults who have faced, or are facing, difficulties at work. Resilience is an important tool for helping people to cope, but we have to be careful that it doesn't become a way of

making bullying the victim's problem.

Effectively, by saying, 'be resilient', we are once again telling victims of bullying to toughen up and ignore it. This may help the victims deal better with the situation, but it doesn't challenge the bullying behaviour, nor does it change the culture which allows bullying and undermining to flourish.

To really change things we have to first acknowledge the problem and then say boldly that it is not OK, we will not accept it, and we will not give bullying and undermining a home, anywhere. ■



Sarah Allen is editor of Ireland's Dental magazine. To contact Sarah, email sarah@connectcommunications.co.uk or follow @sarelal on Twitter

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NEW POLICY — NEW DIRECTION?

Over the past number of years, we have seen a shift in thinking in relation to the provision of dentistry in Ireland. This is characterised by the very definition of what we as dentists actually do for our patients. Are we providing dentistry or are we the guardians of our patients' oral health? Or both? Are we dental surgeons or should we really consider ourselves oral physicians?

On that leafy summer's day, when we graduated from our respective universities, our heads were crammed with various aspects of dentistry, from cavity preparation, bridge design, treatment of oral medical conditions and the intricacies of operative dentistry to paediatric dentistry, preventive dentistry and oral surgery/medicine.

The common theme, however, I would suggest, is based on one word: intervention.

It's a nugget of inescapable truth to which our patients cling at all times. One has only to review the relatively low uptake of the PRSI and Medical Card Examination – both free to patients. Patients appear to place little store in items of service they perceive to be non-interventionist. How many times in our surgeries have we heard the words after a long examination: "So, you're doing nothing for me today then?" This is usually uttered after an extensive inspection of soft and hard tissues, high-yield intra-oral radiographs, careful

CPITN recording, a detailed medical and dental history etc.

The preventive, non-interventionist aspects of oral health such as oral hygiene instruction, dietary advice and timely treatment planning, which absorb a lot of surgery time, seem regrettably less valued by patients than the placement of a filling or removal of a tooth. And we are not alone in this regard; our general medical practitioner colleagues will also cite the issue of a prescription as the interventionist action that most patients seek.

This interventionist "yardstick" has traditionally been embraced by Government as an indicator of productivity. It feeds directly into the "fee-per-item" nature of the Government schemes.

At the time of writing, the new Oral Health Policy is imminent. It's timely therefore to better understand the Common Risk Factor Approach (CRFA) which frames a lot of the thinking of the expected new policy. The CRFA takes a broader perspective and targets risk factors common to many chronic medical conditions and their underlying social determinants. The CRFA's main concept is to devise a concerted approach to combat common health risks (and their social determinants) that will achieve improvements across a range of conditions more effectively and efficiently than the traditional disease-specific approach.

As a "boots on the ground"

clinician, rather than talk in abstract, I prefer to take a practical example. The harmful synergistic nature of alcohol and tobacco and their cumulative effect on oral cancer rates is self-evident. Therefore both alcohol and tobacco are identified as common risk factors for oral health. Alcohol and tobacco are also risk factors for other systemic diseases. By educating our patients and engendering lasting changes in individual "lifestyle" behaviours in those patients, it will achieve improvements across general health – not just oral health.

This is both commendable and important if we, as a nation, plan to reduce the 7,000 deaths per year from smoking-related diseases (Slán, 2007) or the 28 per cent of adults who self-identified as "binge drinkers" (Slán, 2007).

However, this leads me back to where I started. Are we dental surgeons or oral physicians? Will the new Oral Health Policy have provision for training, support and funding for this evidence-informed approach to oral health? If we really are to play our part in the CRFA, are we to be recognised and rewarded for same? These, and other questions I hope will be answered by the new policy.

But, given the experience above from our patients, where patients exhibit low interest levels in non-interventionist treatment, it will be the patients, as well as the clinicians, who will need to be educated for this broad, fresh approach to oral healthcare provision to have an impact. ■





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Dental professionals head for Brexit exit

Research shows eight in 10 of EEA-qualified dental professionals in UK are intending to leave because of uncertainty

Almost a third of EEA-qualified dental professionals working in the UK are considering leaving the UK in the next few years, and of those intending to leave, more than eight in 10 said that Brexit and the uncertainty about arrangements for EU citizens living and working in the UK was a significant factor in their reasoning. However, more than half of those considering leaving said this might change if their EEA qualifications continue to be recognised in the UK.

These are the findings of new independent research commissioned by the General

Dental Council (GDC) to help understand the potential impact of Brexit on the UK registers of dental professionals. Almost one in five UK dentists, and about the same proportion of new applicants to the professional register each year, have qualified in the EEA.

The large majority of respondents, 84 per cent, agreed that Brexit is leading to a shortage of healthcare workers in the UK, while 75 per cent agreed that it is leading to a shortage of dental professionals. On the back of the GDC survey, the British Dental Association has expressed deep

concerns that the government has thus far been unwilling to engage on growing recruitment and retention problems.

Last year, BDA surveys indicated that more than two-thirds (68 per cent) of NHS practices in England who attempted to recruit in the last year struggled to fill vacancies. Half (50 per cent) of the NHS practices that attempted recruitment had reported issues in the previous year.

The BDA says that recent official data has shown morale among dentists has hit an all-time low, with lower levels of morale



also linked to higher NHS commitments.

BDA Chair Mick Armstrong said: "Government has failed to even acknowledge the scale of the crisis that's been facing dentistry for several years.

"Broken NHS contracts, rock-bottom morale and now Brexit are all taking their toll.

"The writing is now on the wall for too many European and UK-qualified dentists. Government needs to wake up and smell the coffee. NHS dentistry can't be run without dentists."

However, the GDC said it has

seen no evidence of EEA-qualified dental professionals leaving the UK registers since the 2016 referendum, and said this trend continued in the December 2018 dentists' annual renewal.

David Teeman, GDC's Head of Regulatory Intelligence, said:

"Exploring the intentions of

people who are currently able to work in UK healthcare because their qualifications are recognised under EU legislation is essential.

"This research was undertaken before important

issues have been resolved, such as recognition of qualifications, residency rights and access to the UK for existing and prospective dental professionals. Once these issues are settled, we are planning a further round of research, which will aim to provide us with increased insight and aid us in

our planning. We recognise the information could be useful to others; for example, those involved in workforce planning, and will therefore be making it publicly available also."



Mick Armstrong

Claudette Christie launches branch programme with a message for 2019

The new BDA Northern Ireland Branch President, Claudette Christie, has kicked off her year in office with the launch of the 2019 Branch Programme.

The BDA Northern Ireland Branch programme provides a fantastic opportunity for learning, networking and professional development, and the 2019 programme offers a comprehensive range of CPD events, including topics such as include periodontal issues in older patients, supporting prevention while managing child dentition, pain management, and communication with patients.

During a visit to Diamond Dental Clinic in Cookstown where she unveiled the programme, Claudette said: "It's incredibly important that dentists not only keep their skills up to date, but that they get out of the practice, meet other dentists and enjoy face-to-face lectures and events.

"This year's theme is 'Managing the message' and I have invited lecturers to interpret this to bring to us a wealth of CPD. Some are clinical, others are about use of print media and how that has changed, as well as a useful reminder on communication techniques."

The branch also runs social events

including the ever popular Gala Ball, which will be held at the Titanic Hotel, Belfast, on 12 October.

The branch formally welcomed Claudette as president at a ceremony at the Riddel Hall, Queen's University Belfast, in January which was attended by family, friends and colleagues from the dental profession across Northern Ireland and beyond.

Claudette was presented with her chains of office by the outgoing President, Martin W Curran. She told the gathering: "It is an honour to be the 96th President of the BDA NI

Branch. BDA has been a huge part of my life, ever since I was a dental student, and I would encourage all dentists to get involved in their association. The opportunities for peer support, learning and advice are unparalleled and have been of great benefit to me throughout my career."

Claudette previously served as the BDA Northern Ireland Director for 15 years, working to raise the profile of dentistry in Northern Ireland and working on behalf of members on important issues such as pay, regulation and service sustainability.



BDA Northern Ireland Branch President Claudette Christie and branch member Liam Diamond launching the 2019 programme

NI dentists demand answers on NHS birthday investment

The British Dental Association has urged officials to put the £600m NHS “birthday present” to work on prevention activities, following its criticism of the use of proceeds from the sugar levy proceeds.

In an open letter to Richard Pengelly, Permanent Secretary, Department of Health, dentist leaders have sought assurances that any new spending will go to support front-line and preventive services. Officials in Northern Ireland will have full discretion on how new monies are spent, and are not obliged to spend it on the health service.

Dentist leaders have attacked the lack of transparency over the use of the estimated £12.3m proceeds from the Soft Drinks Industry Levy, which are ring-fenced for school sports in England. The Northern Ireland Department of Finance has confirmed that “the 2018-19 funding was not ring-fenced for any particular purpose”.

The BDA is leading calls for a wholesale upgrade to Northern Ireland’s oral health strategy, which it has described as a “museum piece”, which fails to deliver a preventive focus or address Northern Ireland’s status at the top of UK league table for tooth decay. It is now more than a decade old, with day-to-day decisions based on obsolete data from 2003. In Northern Ireland, 72 per cent of 15-year-olds have tooth decay compared to 44 per cent in England and 63 per cent in Wales.

Earlier this year the BDA said



Roz
McMullan

“THE SUGAR LEVY WAS MEANT TO FIGHT OBESITY, BUT IT SEEMS PROCEEDS ARE SIMPLY HELPING ACCOUNTANTS TO BALANCE THE BOOKS”

that Northern Ireland’s dismal oral health statistics have left hospitals facing a bill of more than £9.3m a year for paediatric tooth extractions. In the absence of a government, the BDA has called for a serious long-term investment in prevention to bring down costs. It has called for Northern Ireland to follow pioneering programmes from devolved governments in

Wales and Scotland, which have shaved millions off treatment costs through dedicated early years oral health programmes.

Lack of government in Northern Ireland means it is now the only UK region not to have committed to expansion of the HPV vaccination programme to boys – HPV is a major driver of oral cancers. Oral cancer rates are set to double by 2035 and is increasing faster among men than women. With every year that passes 12,000 more boys in Northern Ireland are left unprotected against HPV-related diseases.

Roz McMullan, Chair of the BDA’s Northern Ireland Council, said: “Health professionals now require assurances that money earmarked for safeguarding the future of the NHS will actually be spent for that purpose.

“This sugar levy windfall was meant to fight obesity, but instead it seems proceeds are simply helping Stormont accountants balance the books. Officials must not make the same mistake twice.

“Sadly, paralysis at Stormont is shutting down strategic thinking and fresh investment across our health service. We top the UK league table for oral disease, yet there are no plans to upgrade our antique oral health strategy, or even extend lifesaving vaccines to protect boys from oral cancer.

“The 70th birthday gift needs to provide a real legacy. Tooth decay remains the number one reason for child hospital admission, and investing in prevention could save our health service millions.”



HSCB reallocation of underspend ‘putting dentistry at risk’

BDA Northern Ireland has hit back at the Health and Social Care Board (HSCB) on its recent decision to reallocate £7.7m of underspend away from the General Dental Services (GDS) budget to “other budgets”.

In a letter to Dr Ian Clements, Chair of HSCB, the BDA Northern Ireland Dental Practice Committee’s Chair Richard Graham challenged the rationale provided by finance personnel to the HSCB’s Board of Directors for the GDS underspend.

He said: “GDPs are under incredible financial pressure, having seen taxable income decimated after eight years of increased costs and constrained fee uplifts, as well as pay cuts.

“Advising board members that the GDS budget is reducing because individuals are now ‘choosing to be treated privately’, and that this won’t have any real impact because ‘we don’t have access issues’ simply won’t wash.

“It’s not just the livelihoods of GDPs that suffers. The HSCB has

also been put on notice that reallocating funds away from dentistry is contrary to the extra investment we need to see in addressing our poor oral health and huge level of unmet need, not least among the elderly population living in care home settings.”

He added: “By attending the February board meeting in person, we had an opportunity to voice our concerns directly with the HSCB Chair, and to board members.

“Our message to the HSCB and to the Department of Health at this time is that their actions – and inactions – are putting health service dentistry at considerable risk.

“Removing commitment payments worth over £3m to GDPs a year, and failing to adequately address the rising costs of delivering health service dentistry with capped fee uplifts, plus a prior approval limit that’s remained static for a decade has resulted in a fee structure that isn’t fit for purpose.”

Research finds potential gum disease link to Alzheimer’s

Gum disease has been linked to Alzheimer’s in new research findings published in the journal *Science Advances*.*.

The publication highlights a study which suggests that *P. gingivalis*, one of the main pathogens involved in tooth loss, may also play a role in developing Alzheimer’s.

The study was sponsored by the biotech start-up Cortexyme Inc. of South San Francisco, California. Co-founder Stephen Dominy is a psychiatrist who in the 1990s became intrigued by the idea that Alzheimer’s could have an infectious cause.

There is as yet no agreement that *P. gingivalis* is behind the disorder, though its important role has been acknowledged. Neurobiologist Robert Moir of Massachusetts General Hospital told the journal *Science*: “I’m fully on board with the idea that this microbe could be a contributing factor. I’m much less convinced that [it] causes Alzheimer’s disease.”

The last comprehensive dental survey of adults found that gum disease affects 45 per cent of the population. The condition varies from mild inflammation to reddened, swollen or bleeding gums and, at the advanced stage, loose teeth. Other studies have found links between poor oral health and conditions such as heart disease and diabetes.

BDA scientific adviser Professor Damien Walmsley said: “This study offers a welcome reminder that oral health can’t remain an optional extra in our health service. Everyone’s life can be improved by regular appointments and good oral hygiene, reducing the bacterial load that’s ever present in our mouths to a level that’s unlikely to cause tooth decay, gum disease or tooth loss.”

* Source: <http://bit.ly/2T1FTG0>

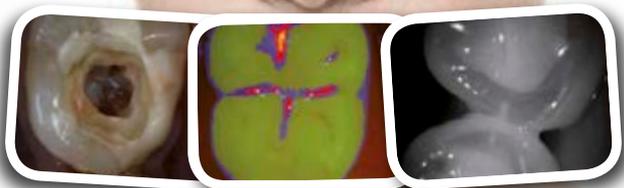
GDC review of CDP

The GDC has published the results of its commissioned literature review of continued professional development (CPD) activities, models and best practice. The review was carried out by the Association of Dental Education in Europe (ADEE) from June to October 2018. Researchers

reviewed over 800 publications on CPD, from across the UK and internationally, and surveyed research areas experts, including those from health regulators, and beyond. The GDC will now use the findings of the review to drive future development of CPD for dental professionals. The full findings of a review can be found on the GDC’s website.

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✓ In brief

1 International preventative care survey

An international research project has asked primary care dentists in the UK, Ireland, Denmark, Germany, and the Netherlands to answer two short questionnaires, which have been developed as part of the EU-funded Added Value for Oral Healthcare (ADVOCATE) project that aims to encourage a preventative approach in dentistry.

The Faculty of General Dental Practice (FGDP(UK)) is one organisation supporting the research by encouraging dentists to participate in the surveys, which can be found on its website. An attitudes questionnaire aims to capture dentists' beliefs and

experiences around delivering preventative care to adult patients; a preferences questionnaire asks dentists to consider clinical scenarios where photographs and radiographs of patients of a given age and caries risk level are presented.

2 Gum disease and pregnancy

A study published in the *Journal of Clinical Periodontology* has found that pregnant women with gum disease are significantly more likely to go into early labour. Research discovered that women who entered labour early were one and a half times more likely (45 per cent) to have gum disease than women who experienced a

perfect pregnancy (29 per cent). The study also found that early birth rates were more common for women with untreated tooth decay or fillings.

3 GDC publishes CPD review

The SDCEP 'Dental Prescribing' app has been updated following amendments to the latest edition of the *British National Formulary* (BNF 76) which was published in September 2018. This update includes information on the 2016 amendment to NICE Clinical Guideline 64 'Prophylaxis against infective endocarditis' and the associated SDCEP Implementation Advice which was published in August 2018.



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<https://dentistrycongress.dentistryconferences.com>

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Same old, same old simply won't do

With more people living longer, the healthcare system is coming under increasing pressure, especially the dental services available to those living in care homes. Those on the front line in Northern Ireland say a new oral health strategy to help the ageing is long overdue

Words: Stewart McRobert

Oral healthcare for older people in Northern Ireland and elsewhere in the developed world is entering a new stage. Successful dentistry in our younger years, rather than being a boon when we age, is bringing myriad challenges. In Northern Ireland the professionals agree – it's time for a new strategy to tackle the issues and provide the comprehensive care that is desperately needed.

Gerry McKenna of Queen's University Belfast has watched the problems for older people gather pace. He explained: "The issues in Northern Ireland are no different from anywhere else. We have an ageing population whose oral health has changed dramatically. People are approaching old age with some, if not all, of their own teeth. We are now having to deal with chronic dental diseases in older people, centred around gum and periodontal disease, as well as dental caries, particularly root caries.

"This is a challenge for colleagues, particularly those in primary care and the community dental service who are faced

with trying to look after large numbers of older patients. Where we are seeing this most acutely is in residential care homes. Older people in homes who have their own teeth are not receiving proper dental care and without access to those services things can deteriorate at a rate of knots."

He pointed out that systemic diseases can aggravate the problems – patients may have very dry mouths and fail to benefit from the natural protection that saliva provides. Equally, there can be challenging nutritional issues. Care homes often put an emphasis on staving off frailty, and in many cases this is done by giving older people highly calorific foods and drinks with lots of sugars and refined carbohydrates.

Again, that can decimate residents' teeth in a very short time.

"Sadly, I don't think our system is adapting to this new realism very well," added Gerry.

"My colleagues in the community dental service who are being charged with looking after patients in care homes are really struggling. The service has been significantly underfunded and they've



Gerry McKenna

“WE ARE NOW HAVING TO DEAL WITH CHRONIC DENTAL DISEASES IN OLDER PEOPLE. THIS IS A CHALLENGE...”





had a raft of people retire who have not been replaced.”

Caroline Lappin, Dental Director for the community dental service (CDS) in the South Eastern Trust area, concurs with Gerry’s assessment. She said: “Our salaried services were traditionally set up as what people termed the ‘school dental service’. We would look after children from backgrounds where there were high levels of tooth decay.

As the population has changed it has become more difficult for general dental practices to look after the elderly population – few general dental practitioners (GDPs) have the time and resources needed to care for our older people.”

“As a result, people in residential homes have increasingly come under the care of the CDS, and it is a major task. In my trust area there are over 100 care homes with a total

A project to test simple interventions

Dental services for care homes are the subject of a research project involving Queen’s University Belfast among others. It will identify the efficacy of a series of simple interventions that it is hoped will have a meaningful impact for care home residents.

Gerry McKenna said: “This is a collaborative project. It is funded by the National Institute for Health Research (NIHR) and we are working with colleagues in the University of Bangor in Wales, as well as University College London, the University of Newcastle and the University of Glasgow.

“We are all aware that there is an increasing issue around the oral health of older people in nursing homes. It’s fair to say that their oral health has changed dramatically over the last 20 or 30 years.

“I’m also aware that there needs to be a very strong package of education for care home staff. There tends to be very high staff turnover in some places so anything we put in place must be long lasting.”

Part of the impetus for the project are recent NICE guidelines (NG48 Oral health for adults in care homes) and the starting point will be to implement a number of interventions in 12 care homes in Northern Ireland, with another 12 homes in London subsequently taking part.

“We are currently going through ethical approval and will look to recruit care homes from May 2019 onwards. The project will run for 12 to 14 months.”

According to Gerry there are huge variations in practice across the UK. “In some places the

community dental service is very active in looking after

residents and in other places private GDPs look after patients – it’s very much on a home-by-home basis. This piecemeal approach has given rise to some of the issues we want to address.

“We are putting the emphasis on prevention and simple measures from the outset and hopefully getting away from big interventions further down the line, with teeth having to be taken out under general anaesthetic.”

It is recognised that residents may have a multitude of conditions and require a huge amount of help from staff, but it is hoped the project will help emphasise that oral health must be a priority, otherwise the consequences are serious. “There are lots of other things care staff have to consider, but oral health is overlooked and it should be brought higher up the agenda,” said Gerry.

“It may be that this piece of work we are doing over the next couple of years can contribute to a new overall strategy for Northern Ireland.

“I would like to see greater emphasis on how we care for older patients, not just those in nursing homes but pragmatic treatment planning for older patients in dental practices.”



There is growing concern that many care home residents who have their own teeth are not receiving proper dental care



For more information on the project see:

www.journalslibrary.nihr.ac.uk/programmes/phr/170311/#/



population of about 3,700 residents.”

According to Caroline, the evolving situation for older people has been witnessed by her own staff. “One of our responsibilities is to screen care homes every 12 to 18 months. That gives an insight on people numbers, age brackets, oral health status, whether someone has a dentist, if they require treatment and so on.

“As time has gone on we have been picking up more and more people who have teeth and/or very good dental work that’s been carried out by GDPs – advanced crown and bridge work, implants and so on. We are now wondering how we support these people so they keep this good dentition for longer.”

However, the CDS is very small in number, especially in comparison to the general dental service. For example, Caroline’s trust area has just 15 dentists. Their job involves covering everything from hospital sessions to looking after patients referred by GDPs,

doctors, social services and district nurses, as well as caring for people with disabilities and, whenever there is time, getting involved in oral health promotion.

She believes that one of the most important tasks is to get the preventive message across. People in the wider population need to be made aware of the importance of caring for everyone’s mouths, no matter what age they are. “There’s an awareness project for care homes staff being carried out in our own area. It is difficult – the staff don’t see brushing residents’ teeth as part of their role.

“This doesn’t have to be clever or complex – it’s



Caroline Lappin

about very simple, basic oral care. Although it can be time intensive it certainly delivers rewards. Older people really notice it when their mouth is clean.”

One complicating element is the failure by authorities to make oral health a regulatory indicator. When an inspector visits a care home she/he does not examine its oral health regime. “We would be keen for that to change,” said Caroline. “We know care homes are under a lot of pressure, but if this was made mandatory it would bring great advantages to residents.”

Solutions

Grainne Quinn is Caroline’s equivalent in the Western Trust area. She believes the CDS is trying to find solutions as best it can: “Many people don’t have a dentist of their own when they go into a care home and in that case the CDS provides dental care.

“We also provide training for care home staff – some of that we do as group training, some as one-to-one. Our hygienists and oral health co-ordinators deliver the sessions. A lot of the patients have dementia, and problems holding toothbrushes or accepting them into their mouths. The one-to-one training gives staff useful tools and techniques.”

Sadly, that training is often not seen as essential by many care homes with the result that staff regularly opt out.

“The other difficulty,” added Grainne, “is that there is normally high staff turnover. You may deliver training then go back in six months to find people have moved to other nursing jobs or other homes. It means you are starting the task all over again.

“Similarly, we may train staff who visit people in their own homes only to discover they



don't visit the homes at night when people perform their oral health routine. Trying to get consistency can be an issue."

On a positive note, transformation funding has been provided to help take forward some initiatives. Part of that money has gone to a fluoride varnish programme for nursing and residential homes. In the Western Trust area dental nurses have been trained to provide the varnish application. The first stage has taken place and it's hoped to extend that programme in the coming year.

Beyond the community dental service, Gerry said that those in primary care often struggle to identify and deliver the best treatment for older people.

"They have to take into account the many medications taken by older people and the impacts of systemic diseases on oral health.

"They may be asked to undertake domiciliary visits to people's homes. That can be uncomfortable thanks to rules and regulations, especially if they are taking along emergency drugs, oxygen cylinders and so on. It can also involve getting special insurance for their car."

All the while the remuneration for providing the service is relatively poor. As a result there is little incentive for people to provide that care.

Policy

Throughout the UK and developed world, dental professionals and policymakers are grappling with oral health issues faced by the ageing population. Gerry noted: "Some countries may be dealing with this a little better than others, but no one has cracked it.

"On the one hand it is hugely positive that older people are retaining their natural teeth, the trouble is the systems and way dentistry is delivered have become outdated. The oral health needs of our older population are now very different. This has implications for dental education and the way services are delivered. We are simply struggling to catch up."

He insisted that a number of steps need to be taken. "We need an oral health policy targeted toward older people in Northern Ireland. There needs to be a coming together of all of the interested parties – those of us from the academic world, colleagues in the community

service and in primary care, as well as those involved in policy making. We also need to involve medical care and the nursing home sector. We need an evidence-based, pragmatic, prevention-driven policy for our older patients.

"Similarly, we need a focus on gerodontology in education, both in terms of what we deliver to undergraduates and what is provided through continuing professional development. We can devise postgraduate courses that can upskill our professionals in the way they deal with and manage older people."

Caroline believes action is overdue. She said: "In Northern Ireland there's a lack of direction from the Department of Health. An oral health strategy was published in 2007, but hasn't been updated since. It would even be good to have some guidance and direction that would help us encourage other stakeholders.

"It would also help if there was a

BDA puts put board on notice

The British Dental Association (BDA) in Northern Ireland has put the health and social care board on notice that action is needed to address the gaps in oral healthcare for older

people and care homes.

Tristen Kelso, BDA Northern Ireland National Director, said: "Richard Graham, Chair of our Dental Practice Committee, recently wrote to the chair of the Health and Social Care Board to highlight a number of issues, mainly the recent dental budget underspend, the financial pressures GDPs are under and the gaps in service as far as the older population is concerned – the fees currently make it a charitable activity for GDPs to undertake domiciliary visits; it simply doesn't stack up financially."

The Health and Social Care Board subsequently asked the



bigger driver for more multi-disciplinary work. For example, the diabetes and obesity agendas highlight the same risk factors and there is a lot to be gained if we work with others.

“The CDS is there to look after the worst cases, not every care home in Northern Ireland. Our resources mean that’s not sustainable. Our dentists and dental nurses are very aware of the



Grainne Quin

Head of Dental Services, Michael Donaldson, to give a presentation to its February 2019 meeting. Both Tristen and Richard Graham attended the meeting.

According to Tristen, Michael Donaldson was clear that there are big gaps and that is due to the community dental service (CDS) being under very serious resource pressure. He also pointed out the fee issue in the general dental service (GDS) and suggested a joint policy approach between the CDS and GDS to tackle the growing problem of meeting the needs of people in care homes.

“It was very encouraging that the issue was raised with the Board,” said Tristen. “This is such an important issue that has gone

demands on the service. They do the best they can in difficult circumstances.

“We would be very keen to be involved in developing an overarching policy. We need joined-up thinking and I would like the Department of Health to be listening more. We have a very good relationship with the Health and Social Care Board. Again, though, without a strategy everyone’s hands are tied.”

Grainne added: “We need an overarching strategy because when you are looking to access funding the first thing you are asked is ‘What policy is this related to, what’s your strategy and plans?’

“Also, if we are going to be training carers and staff we need extra investment. That’s a big issue not only in the CDS but for GDSs too. Many of them are willing to get involved in caring for older people. But over the last few years they have pulled back from providing a service because they have not been

unnoticed for years. From a GDS perspective we are really disappointed that we could not use some of the recent underspend in the dental budget and reinvest it in addressing the gaps. Instead it has been lost and taken out of dentistry completely.

“The BDA has been calling very strongly for a new oral health strategy. If we’d had a new policy in place we’d have seen this issue coming down the track, but now we are firefighting.

“This is disadvantaging a vulnerable cohort significantly. As far as we are concerned the Board has been put on notice with Michael’s presentation. They can no longer say that they don’t know what the issue is and we expect that action will follow.”



properly remunerated. In the CDS we are never going to be able to care for all the older population, so it has to be a joint approach.”

Pressing need

The lack of an executive in Stormont, while important, can’t be an impediment to change.

According to Gerry: “Putting our head in the sand and thinking this issue will go away is not the right approach. It’s here now and will become more pressing as we move forward. The oral health community and dental profession in Northern Ireland needs to tackle this now.”

It’s his opinion that the situation requires real leadership so the direction is clear and everyone can begin talking about financial priorities and how we deliver policy.

Despite the problems he detects a readiness to find a way through. “When I speak to people and deliver lectures I see a huge amount of enthusiasm in the profession – everyone realises that this is a huge issue that needs to be tackled. There is engagement from the BDA and some very positive things going on including a major clinical research project (see page 22). There are lots of people doing their utmost to manage the issues but it now requires a coming together of all interested parties.

“Most important, it is something our patients want us to move on with. They know this is a crucial area where action is needed and I’m positive we can make strides forward.” ■



A checklist to help you think about how your behaviour might impact on others (source: www.rcsed.ac.uk):

- Do you listen to the other members of your team or do you do all the talking?
- Do members of your team come to you with ideas or suggestions?
- Does your sense of humour involve jokes that could be racist, homophobic or sexist?
- Do you feel that 'you had it tough so they should too'?
- If you are senior, do you use your position to offer mentorship or do people go to others for this?
- Do you always apologise to someone if you lose your temper?
- Have you written derogatory comments about someone on WhatsApp, Facebook or Twitter?
- Do your colleagues look you in the eye?
- Do you ignore any of your colleagues?
- Do you blame others for problems that occur?
- Do people speak freely in your theatre/clinic or do you dictate how people behave?
- Does banter form a big part of your interactions with others?
- Have you ever fired off an angry email?
- Do you prefer to email colleagues about difficult situations, rather than discuss things face to face?



An assault on dignity

An entrenched culture of workplace bullying and harassment within the healthcare sector is taking a toll on the wellbeing of employees and is having a serious impact on the effectiveness of health services. The clamour for more concerted action to tackle unacceptable behaviour is growing

Bullying within the workplace can take many forms, including verbal, non-verbal, psychological or even physical abuse. It can involve rudeness and constant arguments as well as unacceptable criticism and situations where people are overloaded with work, ignored or isolated from others. It not only has a detrimental effect on people's wellbeing but on their work performance as well. And that's when it becomes a major issue for both healthcare services and patient care.

In recent years the focus of bullying has moved beyond the schoolyard and internet into the workplace, with particular emphasis on people working in healthcare settings. Although there are, as yet, no studies of bullying in the dental sector specifically, the issue is highlighted in a number of healthcare-related studies and surveys in the UK and Republic of Ireland, which include feedback from dentists.

The issue of bullying was described as 'endemic' in the Health Service Executive (HSE) by the Medical Council, which published the results of a survey in 2017 that showed one-third of trainee doctors at all levels said they were bullied or undermined. What was surprising about the research was that the most junior doctor had a greater risk of being the victim of another trainee medic compared to a senior consultant, although this did occur.

The doctors' union, the Irish Medical Organisation, the Irish Postgraduate Training Forum and the HSE signed a new Respect Charter in 2017 in a bid to deal with the problem of bullying and undermining behaviour being experienced by young doctors.

Following the 2018 Health Sector National Staff Survey, which showed that 42 per cent of staff said they had experienced bullying and/or harassment in their organisation in the past two

Examples of bullying behaviour

(source: www.rcn.org.uk)

- Sadistic or aggressive behaviour over a period of time
- Excluding people from meetings for no good reason
- Humiliating or ridiculing others or criticising others in public
- Persistent, unwarranted criticism of others in private
- Treating colleagues as if they were incompetent
- Changing work responsibilities or academic assignments unreasonably or without justification
- Regularly changing work deadlines or work guidelines without warning
- Deliberately withholding information to affect a colleague's performance
- Withholding support in the academic environment or workplace
- Cyber bullying conducted via social networking channels.

This list is not exhaustive: remember, bullying is any behaviour that is unacceptable to you or makes you distressed.



years, the HSE launched an anti-bullying task force to develop a range of measures to root out bullying, including the launch of an Anti-Bullying Awareness Day in February. In this staff survey, 29 per cent said they had experienced bullying and/or harassment from colleagues while 24 per cent said they had experienced it from service users.

This concern is mirrored across the Irish Sea, where the British Medical Association (BMA) said that bullying and harassment are causing lasting harm to doctors and have a detrimental impact on patient care and safety.

The results of the 2017 National Health Service (NHS) England staff survey showed no substantial movement from the previous year in the measures of bullying, harassment and abuse against staff, whether by patients and relatives (28 per cent) or by managers and other staff (24 per cent).

Of the 30,000 doctors and dentists who responded to the NHS England staff survey in 2016, 24 per cent reported that they experienced some form of bullying or harassment in the preceding year: 13 per cent of doctors and dentists said they had been bullied or harassed by their manager, while 16 per cent said they had been bullied or harassed by another colleague.

In Northern Ireland, the 2015 health and social care staff survey showed that 12 per cent of employees had experienced harassment, bullying or abuse from their manager, while 16 per cent say that they had experienced it from other colleagues.

Despite the serious impact on healthcare services there is no law specifically against bullying. However,

under the UK's Health and Safety at Work Act 1974, and the Republic of Ireland's Employment Equality Acts 1998-2008 and the Safety, Health and Welfare at Work Act 2005, employers do have a duty to ensure the health, safety and welfare of their employees, which can be compromised by bullying and harassment.

Bullying may be characterised as offensive, intimidating, malicious or insulting behaviour, an abuse or misuse of power through means intended to undermine, humiliate, denigrate or injure the recipient. Harassment relates to unwanted conduct affecting the dignity of men and women in the workplace. It may be related to age, sex, race, disability, religion, sexual orientation, nationality or any personal characteristic of the individual, and may be persistent or an isolated incident. The key is that the actions or comments are viewed as demeaning and unacceptable to the recipient.

In the workplace, bullying and harassment can come from managers to their subordinates or from individual colleagues or groups of people, but patients can also present bullying behaviours, particularly if their expectations have not been managed and they threaten legal action.

The various healthcare surveys show that very few people subjected to bullying and harassment formally report it. In its recent report on workplace bullying and harassment of doctors, the BMA highlights factors identified as likely to lead to a bullying culture, such as autocratic, target-driven management styles, poor job design, work intensification, and pressures arising from restructuring or organisational change, especially when radical and top-down.



Another factor they raise that can lead to a bullying culture is the hierarchical nature of the medical profession which, along with workload pressure, can increase the likelihood of ‘silent bystanding’ – a failure of colleagues to speak out – which allows bullying behaviour to continue unchallenged.

It must be recognised that some people, particularly managers, may not realise or perceive that they are behaving like bullies and that their conduct is seen by others as unacceptable. They are often highly competitive and successful people who thrive in a different work value system and may not be conscious of the sensitivities of the people they work with.

The stresses at work can also cause people to behave differently, and that behaviour becomes reinforced until it becomes ‘acceptable’ and part of the culture in the healthcare setting. That is why it is important for people to respectfully challenge these behaviours and make it clear to the ‘bully’ that their behaviour is unacceptable.

On its website, the NHS advises people who believe they are being bullied at work to first seek informal advice from a trusted colleague in order to discuss how they might deal with the problem – by sharing experiences with others they may discover that it is happening to other people too.

Other people to consider raising the issue of bullying with include a manager or supervisor (if that is suitable), someone in the organisation’s human resources department or an employee representative, such as a trade union official. If the bullying is affecting someone’s health, then they need to visit their GP. ■

NHS advice on dealing with a bullying situation:

Be strong

Recognise that criticism or personal remarks are not connected to your abilities. They reflect the bully’s own weaknesses, and are meant to intimidate and control you. Stay calm and don’t be tempted to explain your behaviour. Ask them to explain theirs.

Talk to the bully

The bullying may not be deliberate. If you can, talk to the person in question, as they may not realise how their behaviour has affected you. Work out what to say beforehand. Describe what’s been happening and why you object to it. Stay calm and be polite. If you don’t want to talk to them yourself, ask someone else to do it for you.

Keep a diary

This is known as a contemporaneous record. It will be very useful if you decide to take action at a later stage. Try to talk calmly to the person who’s bullying you and tell them that you find their behaviour unacceptable. Often, bullies retreat from people who stand up to them. If necessary, have an ally with you when you do this.

Make a formal complaint

Making a formal complaint is the next step if you can’t solve the problem informally. To do this, you must follow your employer’s grievance procedure.

What about legal action?

Sometimes the problem continues even after you’ve followed your employer’s grievance procedure. If nothing is done to put things right, you can consider legal action, which may mean going to an employment tribunal. Get professional advice before taking this step.

Other resources on bullying:

- GOV.UK: workplace bullying and harassment
- www.nhs.uk/conditions/stress-anxiety-depression/bullying-at-work
- Acas helpline: 0300 123 1100
- Citizens Advice: problems at work
- Equality and Human Rights Commission (EHRC)



How to fight ‘flight or fight’

Words: Niall Neeson

How does it make you feel when your receptionist informs you that “this next patient is REALLY nervous”?

Dental anxiety is something we all encounter on a daily basis. It won’t surprise you to hear that it can cause significant stress for both patients and dentists ¹.

In Ireland it has been shown to cause problems for up to one in five adults ². Remember, this represents a big chunk of our patient base. At times it can seem inconvenient to take extra time for nervous patients but there are huge benefits in managing dental fear effectively – for patients and indeed for us.

There are many factors that can contribute to dental anxiety including genetic or personality factors, mental health and parental influence ³, and it has been shown to be a lot more complicated than the typical bad experience from ‘The Butcher’.

In spite of this, when anxious or phobic patients are asked, they do often speak about a particularly memorable experience – often painted in colourful language vividly describing the sights, sounds, smells and sensations. Sound familiar?

Realistically, despite our best efforts, we have probably all contributed to such experiences in the past. But what can we do to reduce the chances of contributing to dental anxiety in the future?

Well, while ‘fear’ is a normal physiological response to a real or imminent danger, anxiety is different; anxiety is a response to a ‘perceived’ threat at a time when there is no objective source of danger. Anxiety will activate the sympathetic nervous system, release adrenaline and cause those familiar ‘fight or flight’ symptoms.

Importantly, if a ‘perceived threat’ is allowed to develop into a panic attack then the brain will determine it to be a ‘believed threat’. In the future the brain will then treat it as a real and justified fear,





➤ becoming more of a challenge to both patient and dentist (if the patient did ever come back, that is).

Thankfully, this is where we can help.

How? Well, firstly we need to adapt our perception of these fight or flight symptoms. We need to recognise them as a warning sign rather than a hindrance, a sign that we need to do something in order to nip it in the bud for the patient. In doing so we have the power to prevent it from progressing to a full-blown panic attack that will result in a lasting effect.

The good news is that there are lots of quick and simple techniques we can all use to achieve this – we can turn off the adrenaline tap and help the patient to calm down.

Special techniques such as systematic desensitisation, cognitive behavioural therapy (CBT) or hypnosis are fantastic but can require a lot of time, effort and training¹. It has been shown that for the majority of patients simple measures can be applied to manage concerns and fear⁴. These are things that all of us can (and probably do) apply, such as distraction and simply providing information.

Here are six simple tips that don't require any extra time or cost but can make a real difference. Help turn these potentially challenging scenarios into practice builders and good reviews.

1) Set the tone. Think about the music, ambience and smell. Consider how your surgery looks to an anxious patient and what can be done to make it more welcoming and less threatening. Adapting the environment with slow, relaxing music⁵ and essential oil vapourisers⁶ can help to bring down the energy of the room and reduce patient apprehension.

2) Respect the biology of the 'fight or flight' response. We're all from a scientific background and understanding. We all know the sympathetic nervous system leads to tachycardia, sweating and shortness of breath, but other symptoms can affect communication and an actual biological increase in pain perception⁷. Simply having an understanding and appreciation of this can reduce our frustration and stress levels. So the next time a petrified patient asks you the same question for the third time, just bear this in mind. And teach this to receptionists and nurses – their attitude has the power to make it or break it for nervous patients.

“ A SUPERB DISTRACTION TECHNIQUE IS SIMPLY TO ASK THE PATIENT TO OPEN THEIR EYES JUST BEFORE THE INJECTION ”

3) Listen to their story. They have rehearsed it. Meeting a new dentist is a big deal for them, and they are telling you that they don't want the same thing to happen again. Actually listen for clues as to what's important to them and re-assure why your practice is a safe place to be. Knowing that the same thing will not be allowed to happen again will instantly reduce the adrenaline release and will help them to settle and trust you.

4) Provide a sense of control. Research shows the importance a sense of control has for the anxious patient⁸. A simple but clear stop signal goes a long way. Lifting the hand can work fine. I like to use a button clicker – psychologically it gives them a sense of having the power to stop us 'in the palm of their hand'. Believe it or not I use the type that are used to train dogs! Not very glamorous but patients love it.

5) Open your eyes. A wonderfully simple but effective technique that I picked up from Mike Gow in Glasgow. Typically, when a fearful patient knows the injection is imminent they close their eyes, maybe even scrunch up their face or clench their fists. As 'fight or flight' kicks in, they then begin a process of visualising in their own minds how horrifically long and sharp your dental needle is and imagine the extent of pain it will inflict upon them. This sort of catastrophic thinking and expectation probably contributes to the fact that anxious patients do actually feel more pain⁹. A superb distraction technique is simply to ask them to open their eyes just before the injection. As this unexpected command leaves the patient trying to figure out why on earth they have to open their eyes, it completely disturbs the spiral of negativity in their minds and also floods the brain with visual sensory input to process.

6) Slow breathing techniques. I like to follow "Open



Research has shown the importance a sense of control has for the anxious patient

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your eyes” with a focus on slowing down the breathing. Unless you’re into mindfulness or meditation, it may seem a little bit silly the first few times you use it but give it a go – trust me, it works really well. Something along the lines of “one way of helping to feel more relaxed is to take big, slow deep breaths in, to fill up your lungs like a balloon... (you inspire)... and then really slowly breathe out, as though there’s just a small hole in the balloon to let the air out”. A focus on the action itself along with the visualisation act together as an effective distraction. At the same time the control of breathing actually slows down the physiology, reducing heart rate and allowing the patient to feel more in control and less panicked ¹.

These techniques combine beautifully to achieve our goal of upsetting the surge of adrenaline release and successfully fighting the ‘fight or flight’.

Now, we know a certain proportion of patients won’t even get as far as the surgery never mind the chair, and for those patients sedation or CBT are likely to be a more productive approach. But whereas these truly phobic patients are in the minority, techniques like this will apply to everyone and can only help improve their perception of a visit to your practice.

You might be surprised how well they work. So go on, give them a go – for everyone’s sake.



Niall Neeson BDS (Hons) P. GRAD. DIP. CON. SED is the clinical director at Boyne Dental in Navan where he has developed a patient-centred approach for dental phobics



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First bite syndrome: What every general dental practitioner should know

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ABSTRACT

First bite syndrome is an uncommon complication following surgery involving the infratemporal fossa and the parapharyngeal space or deep lobe of parotid. We report a case of first bite syndrome that was referred to our unit in an effort to make GDPs aware of the presentation of, and to highlight the management of, this potentially debilitating chronic pain syndrome.

CPD/Clinical relevance: This paper describes how first bite syndrome may present as a complication following surgery; general dental practitioners should be aware that it may represent the initial presentation of an underlying neoplastic process of the parotid gland or parapharyngeal space.

Objective: The reader should understand the presentation and management of first bite syndrome. The role of a GDP is important in management and potential diagnosis.

Concise precis

General dental practitioners (GDPs) should be aware of the typical clinical presentation of first bite syndrome and refer appropriately to oral and maxillofacial surgery.

Introduction

First bite syndrome is an uncommon complication

following surgery involving the infratemporal fossa and the parapharyngeal space or deep lobe of parotid¹. Patients typically experience pain in the parotid region on the same side as the surgery at the first bite of each meal. It characteristically lasts for a few seconds and gradually improves with subsequent mastication, but returns at the

first bite of the next meal². Symptoms range from mild to severe and can significantly affect the patient's quality of life³.

The actual cause of first bite syndrome is unknown. Most cases occur as a postoperative complication, but it has also been reported preoperatively^{3,4,5} and even spontaneously, without any obvious cause⁶. Most theories on

the pathology of first bite syndrome are based on the concept of sympathetic denervation of the parotid gland either through cervical sympathectomy or ligation of vascular structures alongside which sympathetic nerves travel³. This results in subsequent hypersensitivity of myoepithelial cells to parasympathetic neurotransmitters and elicits a supramaximal contraction of myoepithelial cells during the first bite of a meal and subsequently subsides with continued mastication⁷. We report a case of first bite syndrome which was referred to our unit in an effort to make GDPs aware of the presentation of, and to highlight the management of, this potentially debilitating chronic pain syndrome.

Case report

A 50-year-old female initially presented to the ear, nose and throat team with a left-sided level II neck mass, which had slowly increased in size over a six-year period. Medically she was fit and well, and a non-smoker. Three years previously she had undergone a mandibular advancement osteotomy with insertion of a chin prosthesis for a high angle Class II Div I malocclusion and had made an uneventful post-operative recovery.

Magnetic resonance imaging (MRI) and ultrasound-guided fine needle aspiration cytology were suggestive of a benign neuroma most probably arising from the vagus nerve. She proceeded to have surgical excision of the lesion, which was histologically confirmed as a schwannoma, most likely arising from the ansa cervicalis. At a subsequent review appointment two months after her surgery she complained of pain

“ FURTHER INVESTIGATIONS ARE ESSENTIAL IN ORDER TO IMPROVE UNDERSTANDING OF THIS CONDITION ”

over the left side of her face around her temporomandibular joint (TMJ) and she was noted to have mild Horner's syndrome on the left side.

The patient was referred to oral and maxillofacial surgery querying TMJ dysfunction. She complained of severe shooting pains over the left side of her upper neck, angle of her jaw and around her TMJ on the left. Pain was reportedly worse on biting and eating, especially with the first bite of a meal. She did not complain of any background pain and felt she could relate the onset to her previous neck surgery.

Clinical examination revealed a scar over the left side of her neck in keeping with her previous neck surgery (Figure 1). She was tender over the left TMJ to palpation; it had a full range of movement which was pain free. There was also some tenderness noted over the muscles of mastication on the left side.

Intra-oral examination revealed no obvious source for her symptoms and although she had amalgam restorations in her upper and lower molars on the left (Figure 2), none of her teeth were tender to percuss or elicited an abnormal response to sensitivity testing. Orthopantomogram revealed thin condyles only with no obvious dentoalveolar pathology. A computed tomography scan showed mild thinning of the condyles with no

evidence of pathological deterioration. A diagnosis of TMJ dysfunction was made and it was felt this may have been a complication of her previous mandibular advancement surgery three years previously. Initial management was conservative with advice on analgesia, soft diet, warm compress and myotherapy of the muscles of mastication.

At subsequent review appointments the patient reported a mild improvement in symptoms while following conservative measures. However, the history became clearer that the sharp pain she was having had occurred with the first bite of each meal and eased with subsequent bites. In addition the pain was worst with the first meal of the day. She also reported no background pain.

A clinical diagnosis of first bite syndrome was made and was supported by the established association between this condition and Horner's syndrome. It was felt that this was most likely a complication of her previous neck surgery for her schwannoma. An MRI was performed to exclude any other lesions which may give rise to first bite syndrome. She was initially treated with non-steroidal anti-inflammatory drugs (NSAIDs) and gabapentin. However, this failed to control her symptoms.

Following a review of the literature she was commenced on carbamazepine and the dose titrated to effect⁷. She was able to tolerate a dose of 400mg daily but was concerned that any higher dosage would make her feel overly drowsy. Her symptoms were less severe and better controlled on carbamazepine; the pain on first bite was not as extreme and settled much quicker with subsequent mastication. We discussed the injection of



▶ botulinum toxin into the left parotid gland as a treatment option^{8,9,10} but she declined this. The patient remains under outpatient follow-up, and feels that her symptoms are tolerable at present.

Discussion

Surgery which involves extensive dissection in the parapharyngeal space is associated with multiple complications due to the complex neurovascular anatomy within this region¹⁰. Complications such as vocal cord palsy, palatal weakness, and Horner's syndrome may be expected due to essential sacrifice of nerves involved in the pathology. A less predictable complication of these surgeries is first bite syndrome. The proposed pathophysiology behind this was originally described by Netterville et al¹¹ in 1998. It is believed that sympathetic innervation to the parotid gland is either damaged or lost in the extended dissection of the external carotid artery where these fibres run. Loss of sympathetic input leads to hypersensitivity of sympathetic receptors on the myoepithelial cells of the parotid gland.

Cross-stimulation of these receptors by parasympathetic release of acetylcholine is believed to cause a hyperintense contraction of these myoepithelial cells which results in the pain described by patients in the first few bites of their meals¹⁰. This is the rationale for the treatment with intraparotid injections with botulinum toxin as it blocks acetylcholine, and this blockade of neurotransmitters decreases the intense myoepithelial contractions

derived from the cross-stimulation of sympathetic receptors, in doing so relieving the pain experienced on initiation of mastication⁹.

Most reported cases of first bite syndrome have been documented after surgery; however, in the absence of ipsilateral upper neck surgery it may be the first presenting symptom of a malignancy of the deep lobe of parotid, submandibular gland or ipsilateral parapharyngeal space^{3,4,5,12}. It has also been reported as idiopathic first bite syndrome in patients without a history of surgery or without any evidence of neoplasia^{6,13}. General dental practitioners should be familiar with this chronic pain syndrome as patients may present to them in the first instance relating their pain to biting and attributing it to an underlying dental pathology.

The diagnosis can be made by taking a good history and by thorough clinical examination. It presents clinically as an intense, paroxysmal, electric shock, cramping or spastic pain arising in the region of the parotid gland or TMJ which rapidly spreads along the mandible¹⁴. It is triggered by chewing, swallowing or even by simple contact with food, the trigger varies, it may be solid or liquid foods but is always acidic. The symptoms may be reproduced by stimulating salivary flow via intraoral lemon glycerin swabs¹³. This pain only lasts for several seconds and tends to wane with subsequent swallows, but it recurs after pausing for several minutes or at the following meal. It is also reported to be most severe with the first meal of the day. Some

patients find that manual compression of the painful region helps to relieve pain, leading them to press over the painful region preventively before taking the first bite¹⁴. The onset of the pain may be preceded by ipsilateral upper neck surgery, parotid surgery or orthognathic surgery.

Careful extra-oral examination may reveal a surgical scar in keeping with previous cervical neck (Figure 1) or parotid surgery. Deep palpation should be systematic and thorough to exclude any new neoplasia or neck mass presenting as first bite syndrome. Examination of the TMJ should be performed and would be expected to be unremarkable.

Another extra-oral sign that may arouse suspicion is evidence of Horner's syndrome, pupil constriction (miosis), ptosis and ipsilateral loss of sweating (anhidrosis). This may be a post-surgical complication also, or arise suspicion of a new lesion of the superior cervical ganglion or sympathetic branches travelling along the internal carotid artery. As with any dental patient, careful intra-oral examination should be performed to exclude any dentoeveolar cause for the patient's symptoms. The occlusion should be assessed carefully, especially if any recent restorative work has been carried out, heavily restored teeth should have percussion testing and sensitivity testing performed and where appropriate radiographs taken.

In the absence of any clear dental pathology, and with a history that arouses suspicion of first bite syndrome, any dental treatment should be avoided,

and the patient should be referred onwards to the closest maxillofacial surgical unit or ear, nose and throat department for further investigation and to initiate treatment. The dentist should be sympathetic and recognise that this chronic pain syndrome can have a considerable impact on the patient's quality of life. The patient may become anxious even at the idea of having a meal and may modify his or her eating behaviour.

Multiple treatments have been attempted to control the pain of first bite syndrome, but few have been successful in completely resolving it. Treatments can be divided into four main categories: dietary modification, pharmacological treatment, radiation therapy and surgical treatment. Dietary modification has been found to be completely ineffective^{10,11}. First-line treatment often consists of NSAIDs used as analgesics in combination with anticonvulsants such as carbamazepine or calcium channel blockers, such as gabapentinoids, or tricyclic antidepressants with anticholinergic effects, such as amitriptyline¹⁴. Although some pharmacological options have been reportedly effective, most notably carbamazepine and pregabalin¹⁰, it appears that responses to all these medications varies between individuals¹⁵.

Radiation therapy has been proposed as a viable treatment for first bite syndrome in relation to oncology patients¹⁶. The side-effects of radiotherapy, however, are numerous and the morbidity associated with it means it cannot be justified for the treatment of

first bite syndrome alone when safer modalities exist.

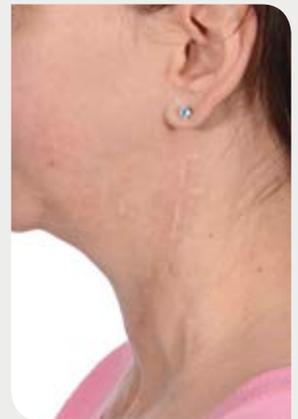
Permanent solutions to first bite syndrome have been sought by surgical means, but these also come with a risk of morbidity. Total parotidectomy appears to be the most effective surgical intervention. However, it is also the most radical and is most notably associated with the risk of injury to the facial nerve. It has been associated with complete resolution in several cases^{3,4,5}. Less radical surgical interventions such as tympanic neurectomy have been reported as unsuccessful¹⁸. Amin et al 2014 describe treating a case of first bite syndrome refractory to non surgical management with laser tympanic plexus ablation, they achieved resolution of her symptoms at three-week and two-month follow-up.

Netterville et al 1998 reported auriculotemporal nerve resection to be effective initially but the long-term efficacy is unknown.

More recently many authors appear to favour the use of botulinum toxin injections into the parotid gland and have argued pharmacological measures should be skipped in favour of this as first-line treatment¹⁰. Lee et al 2009 noted significant improvement but not total relief of symptoms using 33 units of botulinum toxin injected into the ipsilateral parotid gland. Ali et al 2008 and Sims and Suen 2013 reported complete resolution in three out of four patients treated with injection of 75 units of botulinum toxin into the ipsilateral parotid gland. The other patient had almost complete relief of symptoms with

Figure references

1



Surgical scar left side of neck from previous neck surgery

2



OPT showing heavily restored posterior molars bilaterally but no dentoalveolar cause for her symptoms.





significant improvement in quality of life. The symptoms were found to begin to return gradually within three to five months and patients did not seek further injection until five to eight months¹⁰. There were no side-effects of the injection treatment reported.

Conclusion

First bite syndrome may present as a complication following surgery to the parapharyngeal

space or deep lobe of parotid. However, GDPs should be aware that it may represent the initial presentation of an underlying neoplastic process of the parotid gland or parapharyngeal space. It has also been reported as idiopathic without any cause found. Patients may attend their GDP in the first instance as they attribute the symptoms to underlying dental pathology. A thorough clinical history and

examination is diagnostic and suspected cases should be referred appropriately. Treatment options have a variable effect and often only work in the short term.

Further investigations into the pathophysiology of this chronic pain syndrome and pharmacological treatment for first bite syndrome are essential in order to improve understanding and manage this condition more effectively. ■

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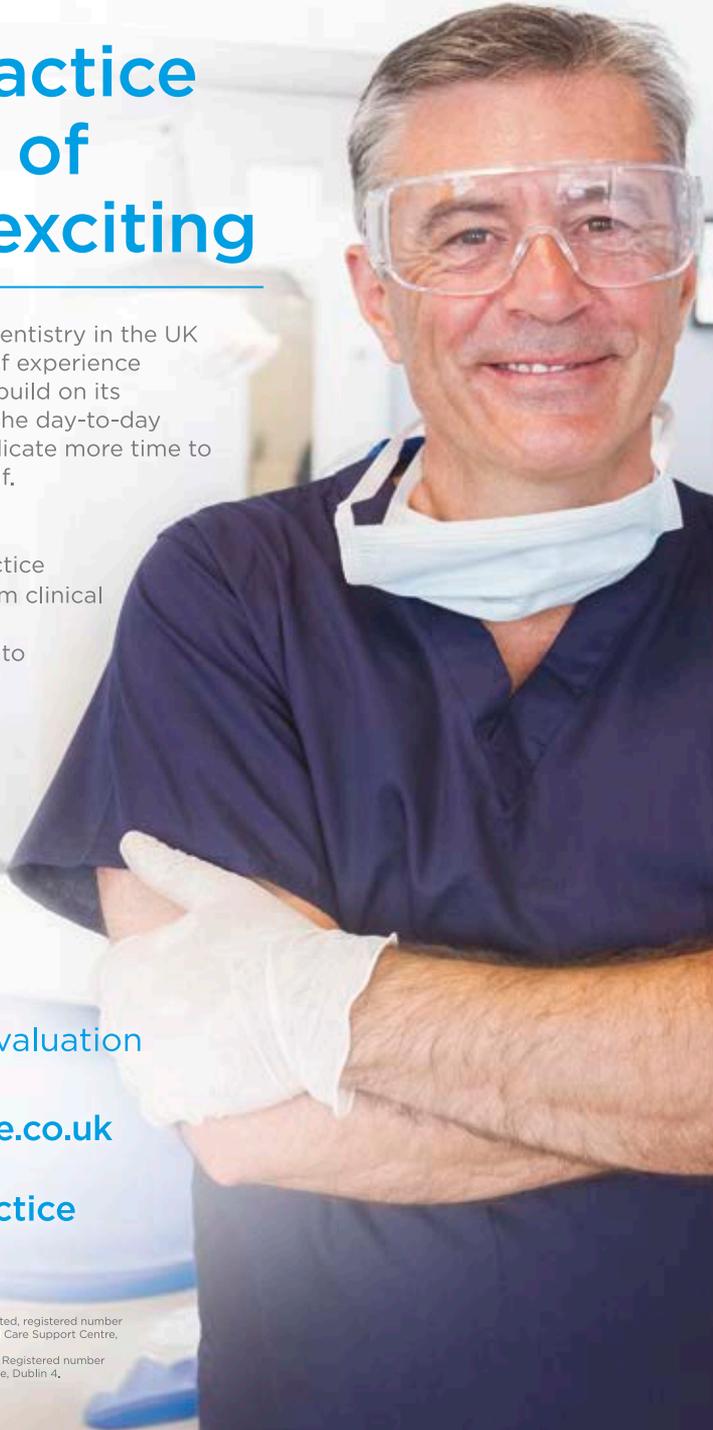
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Encouraging patients to take control of their own dental health might not be a popular move among some people, but it will pay off in the long run

Alun K Rees

In his final lecture before our graduation in 1978, the Dean of Dentistry in Newcastle, Professor Roy Storer, waxed lyrical about our futures. Many of us listened through a slightly hungover haze as our post-finals results' celebrations were ongoing. I do remember well that he made a couple of points relating to changes that he foresaw. First, that we would be dealing with an ageing population, and second, that we must learn to embrace teamwork.

I filed those away, and, anxious to get out into the big world and on with my life, I didn't really consider them again for several years.

As a student the only consideration of ageing I had been taught was preparing patients for dentures. At the time I thought I didn't want to wear dentures so why

would anybody else? Manpower considerations, limited public expectations and an overwhelming amount of disease meant that in many cases wholesale extractions and dentures were the only option offered.

I vowed that dentures would be the very last resort for my patients and so conservation led the first decade of my clinical career.

Sadly nothing lasts forever. Restoring a patient's mouth without ensuring they could maintain it themselves often led to early failure and sometimes more complications that could possibly have been avoided. Certainly there were times when my hopes were unrealistic.

Having spent many hours restoring a mouth with crowns and bridges I watched as the habits that led to the initial

need for complex restorations reasserted themselves and my "clever" dentistry also failed. Sometimes I believe that I may have left patients worse off.

By the time I was ready to be my own boss, with my own practice, four decades had passed since the start of the NHS in the UK. Throughout the world, attitudes and expectations were changing, albeit at different rates. I decided that I must put prevention at the absolute core of everything that I did and I swapped the order around, putting prevention before restoration. Until patients could control the diseases in their mouths, until they could realise that the only way that they could get off the cycle of decay and restoration was for them



Alun K Rees BDS is The Dental Business Coach. An experienced dental practice owner who changed career, he now works as a coach, consultant, trouble-shooter, analyst, speaker, writer and broadcaster. He brings the wisdom gained from his and others' successes to help his clients achieve the rewards their work and dedication deserve.



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➤ to take control I would not embark on major treatment plans. Some patients didn't like my philosophy and sought care elsewhere, at first that hurt, but later, it helped me to sleep more soundly.

My studies with Mike Wise helped me to see that everything, even what appeared to be complex cases, should be done as simply as possible but, as Einstein said, no simpler. The effect on my dentistry both clinical and organisational was profound. For every step there needed to be a straightforward way of reversing, so that no large treatment plan, or indeed part of the organisation, was dependent on one element.

During the 80s and 90s patients were being told that crowns and bridges would "sort

everything out" and they wouldn't have any more problems. As those patients aged and things started to fail the answer was implants, which were, and are, fantastic, but they can also have drawbacks when they are not maintained.

The beauty of the simplicity approach reflected itself as Roy Storer's wise words started to come true. I saw an increase in dental disasters where large numbers of restorations were reliant on, for instance, a root treated, post retained, abutment or where occlusion had led to excess loading.

To return to the other element of Roy's prophecy about teamwork. From day one in my own business, I delegated as much as I possibly could. Firstly to nurses who were all trained in delivering

listening to patients, delivering oral hygiene advice and explaining treatment options. Then we were joined by a full-time hygienist, which raised a few eyebrows as I was the only dentist in the practice and at the time did not have a full "book".

Paradoxically, having the team with expanded roles to whom I delegated as much as I could meant that I got busier. Because I was doing what only I could do, I also became more profitable.

When the time came to remove our reliance on the NHS for adult provision we were well placed and the transition went smoothly. Having shifted the focus from reacting to disease and breakages to being proactive and planning our patient care for the long-term there was far less resistance from

patients who might eventually need extensive, and expensive, care. The vast majority knew what was best for them and often asked me, "is it time yet?".

I'm not going to suggest that all was a bed of roses; life, and particularly dental life, is not like that.

Maintaining a happy team that gradually evolves is challenging but rewarding. Not every patient turns out to be compliant in the long term, some patients arrive with catastrophic dentitions and immediate intervention was required before the patient and I had got to know each other's outlook and expectations.

I still share my philosophy of practice with my clients and have helped many embrace changes for their own success.



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Is your practice management properly organised?

Richard Pearce

Does this sound like you?

- You receive texts from 6.30am from nurses telling you they are sick and can't work today.
- When the suction breaks, you get called, even when you are out collecting the children from school.
- Sales people appear in the appointment book for 'lunch and learn' just when you were looking forward to a free lunch break.
- When popping to the loo, you get stopped by a nurse asking if they can take a holiday... next week.
- You don't really know how well the practice is doing. What's in the bank account seems to allow you to take out enough to afford a lifestyle that is sort of OK
- You hate paying invoices! You get handed a stack of them, which gets added to during the month.
- When you pass reception you occasionally wince when you hear a nurse on reception. She's trying to be helpful but doesn't know how much a crown is and has no idea how to sign up a patient for the plan.
- C2 composite has run out again. You know this because while seeing a patient, a nurse from another surgery has come in and is

- whispering to your nurse and they are rummaging through drawers.
- You chat to an associate as you are heading out the door. They're unhappy about the number of new patients they are seeing but don't know how many it actually was last month.
- You get interrupted every other week with a brilliant advertising offer from the local paper. You tell them that you're not interested at the moment, kidding yourself that it is not in the current marketing plan. Having a marketing plan... That's a laugh!
- You refuse to look at the practice website because it annoys you every time you check it. It's old, lots of information is wrong and you're not even sure anyone looks at it anyway.
- A fuse keeps going in Surgery 2, but someone presses 'Reset' and struggles on.

On the drive home you think to yourself, 'I guess this is what being a practice principal is like!' You live with a constant, underlying feeling of not being in control and wondering where the next 'disaster' will come from.

But, come on! This is no fun. You really enjoy seeing patients, but the rest of it is

just a chore. So how can you get organised and free yourself from this tyranny?

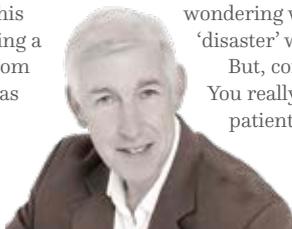
Outsource, automate, delegate

- **Outsource** – Employ a third-party company or individual to manage this task/service.
- **Automate** – Use an online or digital system.
- **Delegate** – Give this task to a staff member who clearly understands the outcome required, how the task is to be completed and how they report on its progress and results.

Only after you have exhausted all three of these possibilities should you consider doing the task yourself.

Let's look at how we DELEGATE first, by starting with the practice manager (PM). When was the last time you reviewed their job description (JD) and confirmed that they do manage all the tasks that are detailed there? Should some of the tasks that you currently do be added to the JD and then you train, monitor and inspect how those tasks are now being completed?

Does the PM 'own' the practice operations manual, which details every procedure that happens in the practice? Here is a tiny snapshot of what should be



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- included in it:
 - materials ordering
 - signing up patients to the membership plan
 - daily cash-up
 - list of preferred tradesmen with contact numbers (examples are given for who deals with what issue)
 - invoice management
 - monthly management reporting
 - float maintenance
 - sales rep booking-in (it's when you want it, not when they happen to be passing).

You might also consider having a separate reception manual, which details procedures specific to front of house.

The staff handbook should cover everything that is related to staff, such as a procedure for requesting holidays.

The PM can also delegate but they might need to be trained on how to train, monitor and inspect effectively.

Now let's AUTOMATE what we can.

- Staff can clock-in with a card clock-in system or app-based system such as Rotacloud, which can also be linked to a payroll system.
- Xero or Quickbooks has invoices scanned to it (Autoentry) and automatically syncs with practice bank accounts. The rules set up mean that assigning income and expenses is a 10-minute per month job, which could be delegated to the PM. So now we have a monthly P & L.
- We know our 'base' materials requirement every month – we order online, once a month. Some items are cheaper if bulk ordered every three months and we have storage space.
- Staff request holidays (and it is authorised) using an online system (Rotacloud again), but there are others.
- As many suppliers as possible are paid by direct debit. We

don't do cash or cheques.

Invoices have to be sent by PDF, this is the 21st century after all (paperless office!)

Finally, OUTSOURCE. A larger practice might consider a bookkeeper coming in one or two times per month to manage this function. They can also prepare forecasts (and provide variance analysis) run payroll and aged debtor reports etc.

Digital marketing, graphic design and web design are outsourced to a specialist agency. You meet with them monthly or quarterly to review the plan and results.

Practices can bury themselves in the weeds and so fail to focus on the big picture. It takes real discipline to take two steps back and analyse what's actually happening. It then takes energy and maybe some investment to change.



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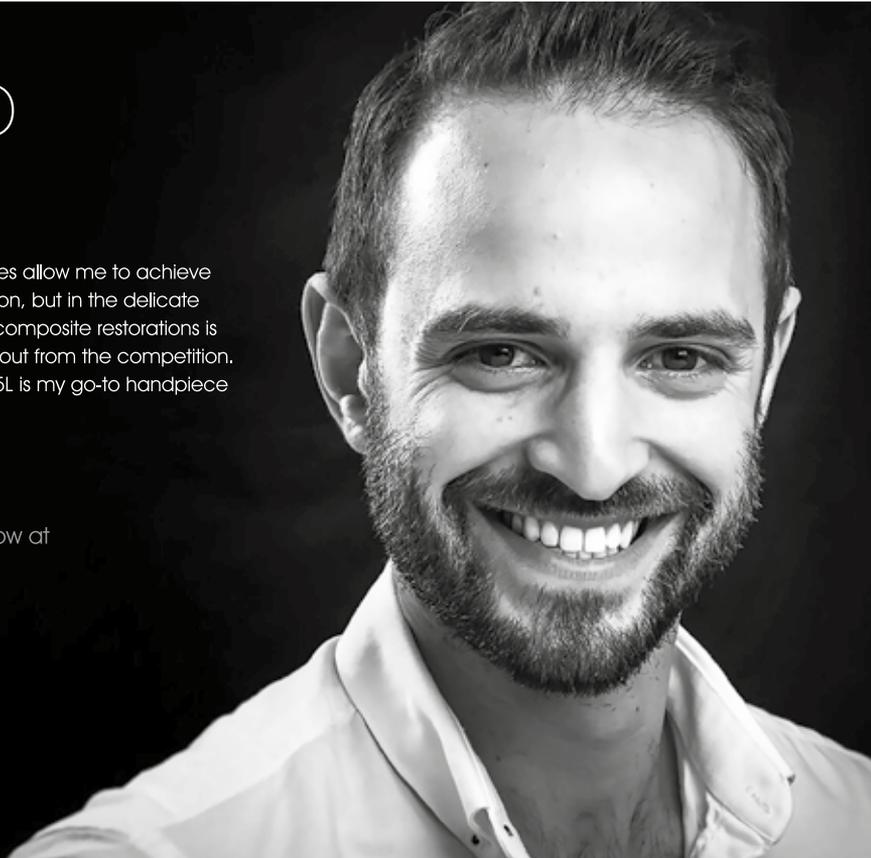
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Dr. Tom Houlihan	Invisalign Indications and pitfalls
Prof Duncan Sleeman	Minor Oral Surgical Problems

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Dr. Trish O'Connor	Relevant Drug Interactions in Dental Practice
Dr. Wendy Turner	Periodontal Problems in the Young
Dr. Garry Fleming	Advances in Dental Materials
Dr. Suk Ng	Cone Beam CT Indications and Interpretations
Dr. Hal Duncan	Regenerative Endodontics

MARCH 23rd 2019

Dr. Michael O'Sullivan	Review of Research Literature : Fact or Fiction
Dr. Shane Mullane	Implants : Surgical Aspects in Partially Dentate
Dr. Shane Mullane	Implants : Prosthetic Aspects in Partially Dentate
Dr. Paul Quinlan	Implants : Surgical Aspects in Edentulous
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APRIL 13th 2019

Dr. Jane Renehan	Infection Prevention & Control – 4 things you must do
Dr. Donal Blackwell	Contemporary Aspects in Adhesive Bridgework
Dr. Anne Gunderman	Smile Design
Dr. Ciara Scott	Functional Appliances: Argument in Favour
Dr. Niall McGuinness	Functional Appliances: Arguments Against

MAY 11th 2019

Dr. Donal O'Shea	The Obesity Epidemic, how can the dentist help?
Dr. Grace Kelly	Management of the Obese patient in practice
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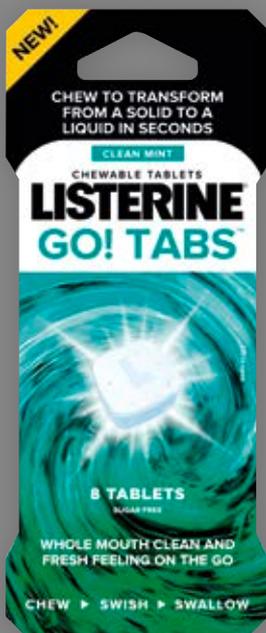
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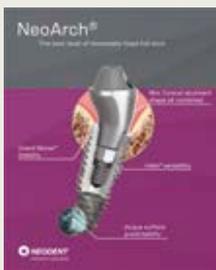
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*Reference: Sartori IAM, Latenek RT, Budel LA, Thomé G, Bernardes SR, Tiossi R. Retrospective analysis of 2,244 implants and the importance of follow-up in implantology. Journal of Research in Dentistry. 2014 Nov- Dez;2(6):555-564



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