UK and Ireland

Dental Protection

Riskmatters

Topical issues and risk management for dentists at the start of their career

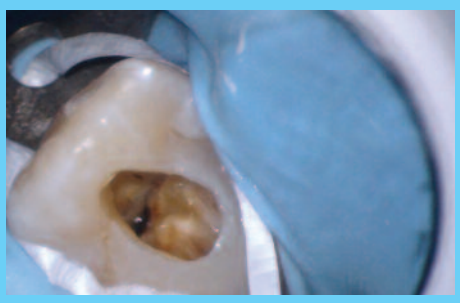
Inside issue 30

Everyone is talking about YDC 2015

Three articles prepared by this year's speakers appear on pages 5–12

www.dentalprotection.org

Contents



Editorial

James Foster
Senior Dento-Legal Adviser

Dear Colleague,

It often seems that the most popular dental events are the ones which are perceived as being most enjoyable to attend; possibly because some of the subject matter is familiar. But popular appeal doesn't always deal with more pressing educational needs.

Once the undergraduate course has been completed , the learning process has really only just started and it is all too easy to select only the subjects that seem topical and speakers who are popular.

Knowledge gaps

Dental Protection has heard from members, about situations where a secondary care provider has refused to accept a referral because it is felt that a general dental practitioner should be capable of providing the treatment in question – frequently this involves molar endodontics or oral surgery.

The dentist will often explain that they are not particularly good at endodontics and oral surgery and so do not feel competent to undertake the treatment. Meanwhile, routine endodontics and exodontia is considered to be a core dental skill and as such a GDP might normally be expected to provide treatment.

This scenario suggests a learning need that would pay dividends if the situation were to arise again in the future. It was for this reason that two of the speakers at this year's Young Dentist Conference were chosen for their expertise in these two topics.

Development

For those who were unable to attend the conference, Simon Stone (endo) and Julie Cross (oral surgery) have summarised the main points of the talk that they gave so that a wider audience can benefit from their expertise.

It may also serve to help some readers to adopt a more proactive, personalised and focused approach to planning our learning needs by way of a Personal Development Plan (PDP). The dental team is now being encouraged to think more critically about their actual training needs, to prioritise them and formulate a plan to achieve them.

A PDP is basically a written scheme that records all of these activities in an easily accessible format. It also enables us to demonstrate to any interested third party that we are committed to a formalised approach to our learning.

It is an area of professional life that all members of the dental team should move towards. It is also a concept which is slowly becoming a feature of the General Dental Council's registration process.

More

Another speaker from that conference was Reena Wadia whose tips on surviving the first years in practice offer a different insight into clinical practice.

I hope these articles will be inspiring for those who missed the opportunity the first time round and serve as a practical souvenir for those who attended the event. Indeed the delegates are the ones who can confirm that education, learning and enjoyment are not incompatible, and I know that our events team will ensure that this philosophy is maintained in all future events including the Horizons roadshow in September. Recent graduates are particularly welcome at these events and I look forward to seeing some of you there.

Best wishes,

James Foster
LLM BDS MFGDP(UK)
Senior Dento-Legal Adviser
james.foster@dentalprotection.org

Horizons roadshows
Save the date!

Dental Protection is pleased to announce the dates and locations for this year's Horizons roadshows; a series of events relevant to the whole dental team.

Newcastle
Copthorne Hotel
Monday 7 September
Sheffield
Hilton Hotel
Tuesday 8 September
Cardiff
Copthorne Hotel
Wednesday 9 September
London
Cavendish Conference Centre
Thursday 10 September

Presentations will be delivered by Dental Protection's senior dento-legal advisers and will cover the risky business of dentistry, with examples from Dental Protection's extensive archive of clinical cases. We will be discussing how claims are dealt with and what is happening with Fitness to Practice cases at the GDC.

These events are the perfect opportunity for you and your friends to meet and network with established dentists and practice owners in your area, so don't miss out, book your place now!

Email events@dentalprotection.org or call us on 020 7399 2914 for more information.

News

Renew online

Dental Protection now offers a new service for final year, first and second year post-graduation membership. That's right you can sign up and renew your membership via our website.

The Dental Protection early bird renewal period has been extended until 31 July. To take advantage of the great early bird discount renew your membership for your second year post-graduation (September 2015 – August 2016) before 31 July 2015. This lets you sort your protection arrangements early so you don't have to worry about it later.

We're a mutual membership organisation, and we don't set our subscriptions to make a profit. 75% of young dentists in the UK are Dental Protection members

To renew, please log into "My MPS" at www.dentalprotection.org/renewonline. If you do not have an account, you can register with your membership number.

If you have any questions about your renewal, please contact the Member Operations Centre on 0800 561 9000.

Choosing a new practice

The last three issues of *Riskmatters* contained an article describing the choices that have to be made whenever a young dentist wants to choose a new practice. They were very well received and, in response to many requests from members, we have reviewed the text and published it as a downloadable booklet. You will find it on the website in the "Advice Booklet" section under the "Publications" tab.

theyoungdentist.com

theyoungdentist.com is a unique platform from Dental Protection, featuring content created by young dentists for young dentists to help support you in the early stages of your career with a wide range of articles, practical tips and case studies. You can also find out about our regular events including the annual Young Dentist Conference.

Why not write an article and share your own experiences with other dental professionals around the world? If you would like to share your thoughts, please contact theyoungdentist@dentalprotection.org

Update your details

As a young dentist you may move around and in turn change your address. Please update your contact details to ensure you get the most out of your Dental Protection membership.

You can do this by logging into My MPS on the Dental Protection website.

Young Dentist Conference 2015

Dental Protection's Young Dentist Conference 2015 featured five excellent presentations from an exciting panel of speakers, and covered contemporary topics such as endodontics, NHS/private practice and oral surgery. You can read more about the presentations on pages 5–12.

Keep an eye on the website for the dates of future Dental Protection events. Don't forget, as a member of Dental Protection you get a discounted rate on tickets

Don't miss the next issue of *Riskwise* coming in July. It's full of topical risk management advice

Young Dentist Conference 2015

Over 200 delegates attended the **10th annual Young Dentist Conference** at the Royal College of Physicians earlier this year

The Conference is organised by Dental Protection in conjunction with the British Dental Association and the British Dental Journal. The programme is dedicated to the specific needs of dentists in their first five years of practice

This year's programme featured a panel of five excellent speakers and we invited three of them to summarise some of the key points of their presentation to share with those of you who were not able to attend

Reena Wadia, a young dentist with a passion for communication shared her top tips for success Julie Cross is an oral surgeon and she described the importance of being prepared for the tooth that breaks during extraction Simon Stone discussed the predictability of root canal treatment in general dental practice and knowing when to involve a specialist

Survival of the fittest

Dentistry can be a testing environment; **Reena Wadia** offers a selection of ideas to help you evolve into the perfect practitioner

There are more dental graduates in the UK than ever before and, with the uncertainty in the job market, competition is fierce. Today's young dentist is also qualifying with less clinical experience than his or her predecessor; a more litigious environment and slashed NHS funding are extra challenges, too. However, it is still possible to build a successful career in the current environment. These are my top five tips to surviving – and excelling – as a young dentist

Reena Wadia
Reena qualified from Barts and The London. She is currently completing part-time specialty training in periodontology at Guy's as well as working in general practice

1) Have confidence in yourself – and confidence to ask for help

You've qualified and are now free to practise dentistry without having someone peering over your shoulder – great! But, it can also be a daunting thought that you must now make decisions for yourself. Rest assured, your confidence will slowly develop – you will generally do more work in the first few weeks of practice than you ever did at dental school! Always remember to keep the patient's best interests at heart.

Never be afraid to ask for second opinions or discuss cases with colleagues – we've all been there. When help is available, attempt different treatments but remember, don't be tempted to dive in without the help of an experienced clinician and be mindful of the extent of your competence, too, before practising new skills alone.

2) Fine tune record-keeping and communication skills

With the time constraints of a busy NHS practice, it is easy to pick up bad habits when it comes to record keeping. But, time spent on detailed records may save you hours of stress (and, possibly, a legal case). During the appointment, dedicate time to accurately completing the patient's records.

Actively listen to what your patients are saying, paying attention to tone and inflection as well as to their body language. Take time to try to understand their expectations; these may need modifying if unrealistic. Treatment decisions should be made together after a thorough and balanced discussion.

If you don't have a fantastic memory, jot down some personal details on the patient's record to jog your memory. Remember, your patient is an individual, not a set of teeth looking for a treatment plan!

Seek a mentor – a senior clinician whose values and approach matches your own to be a trusted advisor and role model

Never be afraid to ask for advice or to get a second opinion. You will protect the best interests of the patient and learn at the same time

3) Invest in loupes with illumination

There are ergonomic and optical benefits to wearing loupes – and the earlier the better as there is a steep learning curve. Leggat, Kedjarune and Smith (2007) found that approximately 53-82% of dental professionals suffer musculoskeletal complaints such as neck and back muscle pain. Often, poor posture is a contributing factor and loupes enable a clinician to work in a healthier, more ergonomic position. If you can, add a light source to provide illumination, this will improve your vision and reduce eye strain.

4) Take plenty of clinical photos

Photographs can be a valuable part of your patient record and are useful for patient education and liaison with the dental team too. Build up a portfolio of clinical cases – helpful when applying for associate jobs. Importantly, having photographs of your work allows you to reflect, audit and continually improve.

5) Find a mentor

Seek a mentor – a senior clinician whose values and approach matches your own and who can be a trusted advisor and role model. Throughout dental training and beyond, inspirational dental professionals will prove an invaluable source of knowledge that will help you choose the most efficient route to achieve your ambitions.

Patient rules

- Keep the patient's best interests at heart
- Actively listen and take notice of body language
- Spend time discussing treatment plans
- Document all the key points with comprehensive records
- Your patient is an individual, not a set of teeth with a treatment plan!

Here to help

Dental Protection does a lot more than just taking care of indemnity arrangements. That's why we have such a large team of advisers. Whatever problems you face, we have the experience to solve them

Be prepared!

There are many complications that can arise from oral surgery. **Julie Cross** scouts around the common pitfalls and maps out a guide to managing them

When a tooth fractures on extraction you will need to plan what to do next

It is important to be prepared for the possibility of oral surgery procedures in practice. Indeed, access to a basic surgical kit is essential. Dental extractions are one of the most common oral surgery procedures carried out by GDPs

With patients retaining their dentition for longer and often having extractions later in life, the procedure can pose more of a challenge than ever before.

Teeth that are more heavily restored, root treated and surrounded by dense bone, increase the likelihood of surgery so warn the patient of this possibility. Unfortunately, fracturing a tooth during extraction is common, too, and the secret to managing the situation is all in the planning:

Julie Cross
Julie graduated from Glasgow and currently divides her time between Oral Surgery Specialist Practice in Glasgow and the Oral and Maxillofacial Surgery Department at Crosshouse Hospital, Kilmarnock

Here's the plan

1 Inform the patient
2 Make a decision regarding further treatment
3 Decide whether to continue or to refer
4 Be aware of your limitations.

Get a map

Take a radiograph to assess the morphology of the retained root, the proximity of anatomical structures and any underlying pathology.

Surgical extraction of teeth

Figures 1–5

Flap design

Consider the anatomy and potential complications and think about the post-operative aesthetics in relation to the adjacent teeth. The size of the flap should be designed to allow good access for instruments.

Soft tissue surgical or bone removal

Raising a flap may give adequate access for luxators, elevators or forceps without the need for bone removal. However, if there is no application point for these instruments, then bone removal will be required. When removing bone, the clinician should ensure a retractor is used to protect the soft tissues from trauma. Using a retractor also allows a better view of – and easy access to – the surgical site.

Elevators and luxators

Elevators provide an application point for forceps or to move teeth prior to using forceps. They can also be used to remove teeth or retained roots or apices. Luxators are used to create space between a root and supporting bone for the application of elevators or forceps. Care should be taken, particularly in the maxillary posterior region, as tooth fragments can be pushed upwards and into the sinus.

Socket debridement and closure

Once the roots or teeth have been removed, the socket should be debrided and granulation tissue removed. If the bony socket is sharp or rough, smooth it down to prevent trauma to the mucosa during healing.

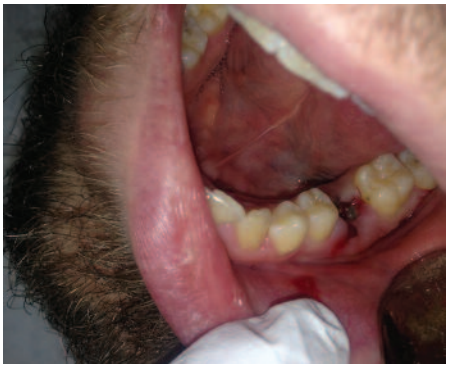


Figure 1
Pre-operative image

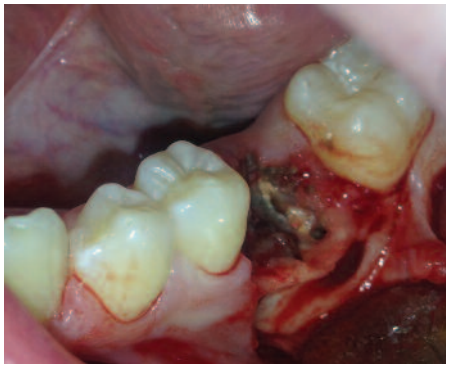


Figure 2
Buccal mucoperiosteal flap raised

Complications

Soft tissue damage
Mucosal tears can occur due to slipped instruments or forceps incorrectly positioned on the lingual or buccal tissues. These may require suturing and, in such situations, the clinician should always inform the patient.

Root displaced into maxillary antrum (Figure 6)
If a root has been displaced into the maxillary sinus during an extraction, the patient should be informed and it may mean referral to a maxillofacial or oral surgery department.

Oro-antral communication following extraction
If the communication is small and the sinus lining is intact, this can be managed conservatively. The patient should be prescribed antibiotics and given nose-blowing instructions. A review should be arranged to ensure healing. If the communication is larger – or the lining is torn – then this will also require closure.

Fractured tuberosity
Fractured tuberosities occur when removing maxillary wisdom teeth or lone-standing maxillary molar teeth. Lack of alveolar support during extraction increases the risk. If the tooth and fractured tuberosity are minimally displaced, then a splint can be used to support the fracture and allow healing.

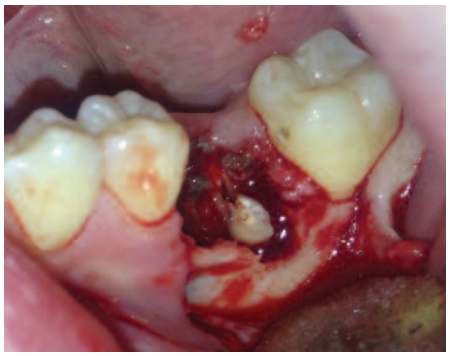


Figure 3
Buccal gutter of bur removed

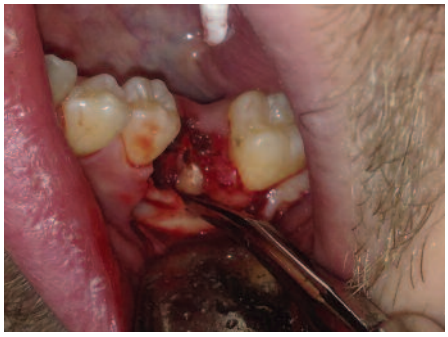


Figure 4
Application point for Couplands Chisel

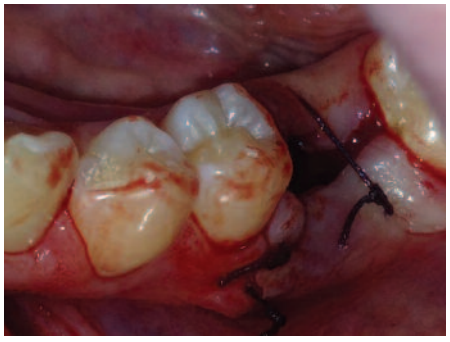


Figure 5
Interrupted sutures placed after socket debridement

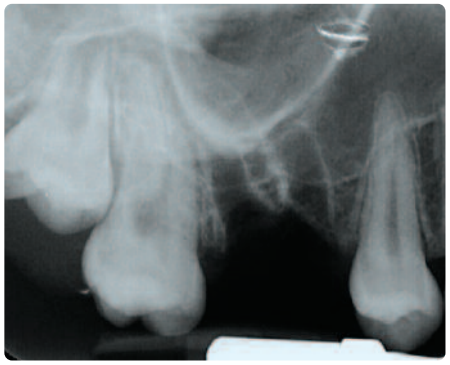


Figure 6
Root of upper right first molar displaced into maxillary sinus

Seven steps to safety

1 Prepare several sterile oral surgery kits
2 Train the dental nurse to assist with oral surgery
3 Assess patients ahead of time on a separate occasion
4 Schedule oral surgery for the start or end of a session
5 Allow more time than anticipated
6 Keep it simple at first and work within limitations
7 Maintain good clinical records.

It's complicated

Simon Stone offers nine steps to ensure success and shares some cases from which we can all learn

More dento-legal cases arise from endodontics than from any other dental procedures

Root canal treatment (RCT) can cause anxiety for young dentists. It requires careful case selection, open patient communication, recognition of clinical limitations and an understanding of when to refer

There will always be endodontic cases that cannot be successfully managed in primary care that will benefit from specialist input. However, early in a career, when a difficult case involves an element of supervision or assistance from a colleague, it can knock the confidence of a young dentist looking to consolidate technical skills.

The situation is not helped by the fact that clinical experience in RCT for younger dentists is variable, with dental schools struggling to find suitable cases for students[1].

Interestingly, however, more dento-legal cases arise from endodontics than any other dental procedures, and recent graduates tend to have a disproportionate share of the problems in relation to this procedure. Here is a short road map to more predictable treatment outcomes.

Simon Stone
Simon graduated from Newcastle. Following a mixture of research, teaching and part-time general practice roles, he is currently a Clinical Lecturer in Restorative Dentistry and Honorary Speciality Trainee in Endodontics at Newcastle University

Step 1 – communication

Frank, open discussions with patients are important. Be honest about potential complications to avoid uncomfortable conversations post-treatment if it turns out that the restoration of the tooth is no longer possible. Be decisive at the planning stage, taking care not to be forced into treatment with a high likelihood of failure. Document those conversations in case there is a need to defend your decision.

Step 2 – clinical comparisons

Clinical trials report endodontic success rates in excess of 90%, but these are often very controlled studies. Are you working to the same protocols, using comparable systems, similar irrigating solutions, and for the same length of time? In reality, you are unlikely to know this until you have been practising for a number of years and have witnessed failures.

Step 3 – case selection

Case selection is critical, with restorability an important consideration. Assess the patient carefully to ensure future patient satisfaction. Complex treatment may not be suitable for patients with a high caries rate, extensive periodontal disease or limited mouth opening.

Step 4 – clinical assessments

Clinical and radiographic assessments of the quality and quantity of the remaining tooth tissue is fundamental. If there is doubt about a tooth's restorability, removing deficient crowns or restorations initially can inform this judgement. At a tooth level, providing RCT may be technically possible, but care should be taken if the remaining tooth tissue is limited or compromised.

Step 5 – diagnostic tests

Patients may present with unusual symptoms that mimic a pulpal or periapical, odontogenic diagnosis. In these cases, the diagnostic thermal, electric, and percussive tests, along with radiographic investigations, will aid diagnosis. Where diagnosis is uncertain, seek a second opinion.

[1] Qualtrough, A. J. (2014) Undergraduate endodontic education: what are the challenges? Br Dent J 216, 361-364. doi:10.1038/sj.bdj.2014.227.

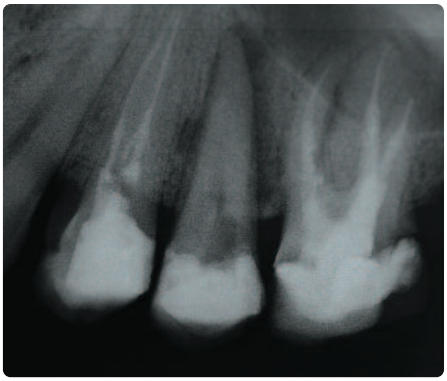


Figure 1
Shows three heavily restored, root filled teeth in the upper left quadrant, deficiencies and caries noted in 14, 16. There have been extensive excavations at 15 both in terms of depth and angulation in an attempt to locate the sclerosed apical anatomy; these have resulted in a sub-bony perforation. There are extensive radiolucencies apically, and at mid-root level mesially and distally. The tooth is not a good candidate for RCT and should be removed

Step 6 – clarity of vision

Without clear vision, identification of complex anatomy becomes even more challenging. Magnifying loupes, with illumination, offer enormous help.

Step 7 – cavity preparation

At the access stage, procedural errors relate to the length, depth and orientation of the access cavity. Teeth are at a greater risk of perforation if they have sclerosed pulp chambers and long, aggressive crown (>8mm) burs are used in access cavity preparation.

Step 8 – canal caution

Caution should be exercised if instrument sequences are curtailed in the interests of cost saving or if instruments are forced into canals to overcome obstructions. Both may result in greater stresses on the instruments and lead to separation (breakage). If this happens, assess the possibility of retrieving the parts – and keep the patient informed.

Step 9 – criteria for referral

When procedural errors occur, or the morphology and the lie of the tooth is unusual, there may be a need for referral to a specialist. Most NHS referral centres will have published guidelines and acceptance criteria. Make available any radiographs to aid diagnosis but, if shared on email, take care to ensure that the data is encrypted so that a third party cannot access details.

When to consider sharing patient care with a colleague:

- Diagnostic opinions
- Anaesthetic problems
- Trauma and its sequelae
- Removal of root fillings if proved difficult
- Canal location
- Fractured instrument retrieval
- Removal of posts
- Perforation repair
- Surgical endodontics.

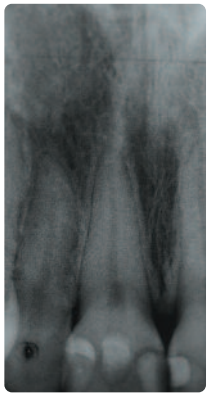


Figure 2
Shows tooth 11 with three separate restorations, secondary caries mesially around the restoration at 21. There is no established apical radiolucency. Whilst the canal appears obvious radiographically, there is a perforation labially resulting from inappropriate access cavity angulation. Whilst prevention of these technical errors is preferable, this high perforation would be amenable to surgical repair

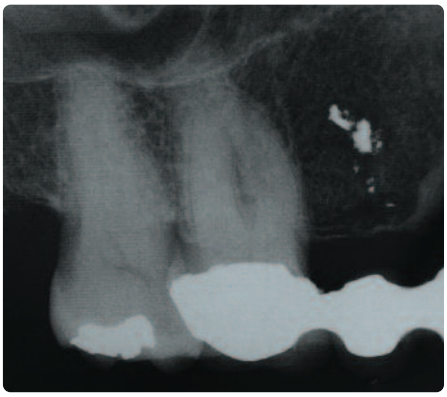


Figure 3
Shows tooth 17 which is minimally restored. Tooth 16 is a retainer for a long span conventional bridge, the mesial abutment is not visible. The root canals are not obvious within the coronal 1/3 of the tooth and the presence of the bridge will likely limit vision and access. There is no apical radiolucency. Consideration should be given to removing the bridge to help locate the canal anatomy, predictability is uncertain in this case. There is amalgam debris in the soft tissues, confirmed clinically by the presence of an amalgam tattoo

It’s complicated

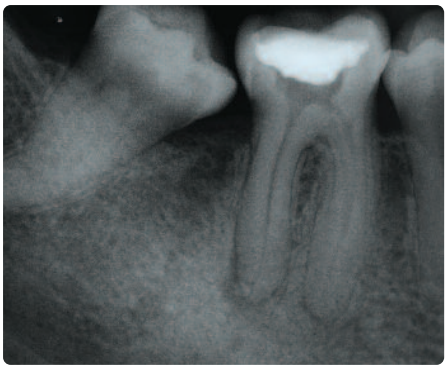


Figure 4

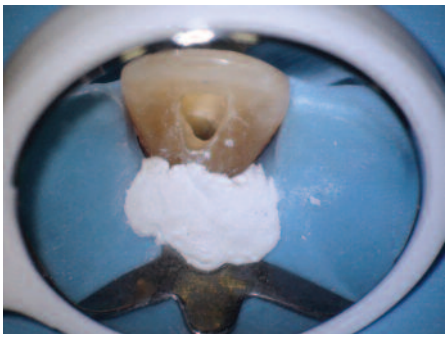


Figure 5

Figure 6

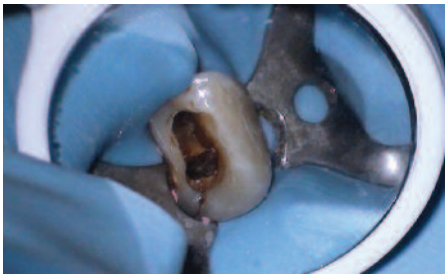


Figure 7a

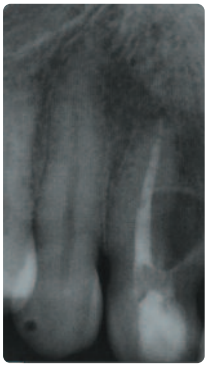


Figure 7b

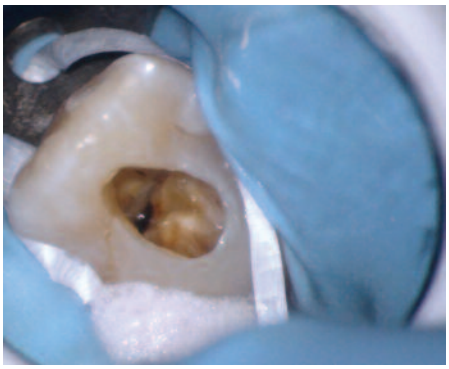


Figure 8a

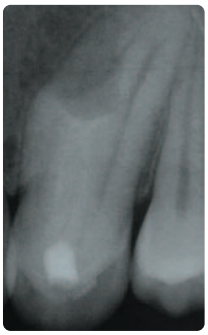


Figure 8b

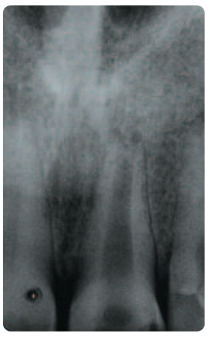


Figure 9a

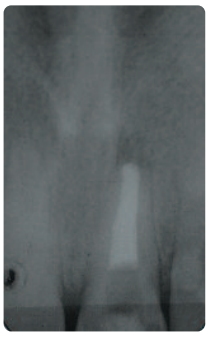


Figure 9b

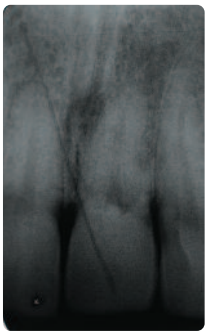


Figure 10a

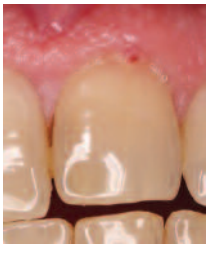


Figure 10b

Figure 4
Shows tooth a moderately restored 46 with intact marginal ridges, the pulp chamber is visible as is the radicular pulp, there is a radiolucency associated with the distal root and widening of the periodontal membrane space mesially. This tooth has a greater prospect of successful root canal treatment and subsequent restoration

Figure 5
Shows 11 isolated with rubber dam and sealed with a caulking agent. The image is captured at low magnification using an operating microscope offering optimal light and vision

Figure 6
Shows safe ended MaxiProbe (left) and Monoject (right) needle designs, which reduce the pressure at which irrigant can be delivered through these syringes

Figures 7a and 7b
Shows clinical and radiographic views of a previously treated, symptomatic 12 with unusual root canal anatomy. Identification of the second canal root was not possible without the use of an operating microscope. This tooth may have better prospects with surgical root amputation

Figures 8a and 8b
Shows an odontome like 23, non-surgical treatment is possible with the help of additional imaging techniques and an operating microscope

Figures 9a and 9b
Shows an adult with a previously traumatised 21 that has an open apex, the use of an operating microscope was helpful in controlling the placement of MTA in the wide apical region

Figures 10a and 10b
Shows external cervical resorption of a vital 21 that requires surgical management

The spirit of summer

With the long, warm summer evenings and the smell of BBQs filling the air, it's all too easy to open a cool beer, bottle of chilled wine or mix up the Pimms

The UK is the sixth biggest wine consuming country in the world despite falling wine sales generally

www.harpers.co.uk

And while the majority of us might enjoy such an evening with no major repercussions to our health, it could be time to step back and remind ourselves, and our patients, of the potentially harmful risks of alcohol on our oral and general health

The facts

While many of us drink alcohol moderately, according to the NHS, more than 24% of people in England alone consume alcohol in a way that's harmful, or potentially harmful, to their health and wellbeing[1]. For men, this is drinking more than the recommended limit of three to four units a day on a regular basis and for women, more than the recommended limit of two to three units[2].

The Health and Social Care Information Centre's Statistics on Alcohol – England 2014, published in May last year, paints a picture of our drinking habits: amongst adults who drank alcohol in the week before being interviewed, 55% of men and 53% of women drank more than the recommended daily amounts[3].

Patient health

As a dentist, you may discuss your patient's alcohol intake with them, and are acutely aware how excessive alcohol consumption can impact on their oral health – as well as the fact that drinking to excess is linked with oral cancer. However, regular conversations about their lifestyle and the recording of their medical history may also highlight potential overall health risks.

Writing for the British Dental Health Foundation, Jonathan Shepherd, Professor of Oral and Maxillofacial Surgery at Cardiff University, supports this by saying: "Since alcohol misuse affects patients' general health, addressing this in primary dental care settings also enables dental professionals to meet wider health promotion responsibilities. Unlike primary medical care, primary dental care services are used by patients on a regular, prevention-orientated basis, with the majority of people attending for a routine check-up irrespective of any oral health problem. This provides the primary dental healthcare team with unique opportunities to intervene, particularly as asking patients about their level of alcohol consumption is a routine component of medical history taking."[4]

[1] http://www.nhs.uk/conditions/Alcohol-misuse/Pages/Introduction.aspx

[2] http://www.nhs.uk/change4life/Pages/alcohol-lower-risk-guidelines-units.aspx

[3] www.hscic.gov.uk/catalogue/PUB14184

[4] http://www.dentalhealth.org/blog/blogdetails/93

The spirit of summer

Sarah Bradbury
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Additionally, the BDA's Oral Health Inequalities Policy suggests dentists are ideally placed to inform and advise patients about their oral and general health risks, including alcohol use[5]. With statistics showing that, every year, alcohol is responsible for around 4% of UK cancers – about 12,800 cases per year – as a healthcare professional, you have an important part to play in educating your patients about the risks[6].

Your health

As you are at the start of your dental career, it is an ideal time to know of the risks that your profession is prone to, such as musculoskeletal issues and stress. In a survey investigating stress management in the dental team, conducted by Joanna Taylor, a dental practice manager, accredited clinical hypnotherapist and Neuro-Linguistic Programming (NLP) master practitioner, out of the 178 principal and associate dentists who took part, more than one third (36%) stated they were stressed about their work during most working days and nearly one fifth (19%) felt stressed every day. The survey also found that popular stress management tools for dentists included alcohol, along with playing sport and reading[7].

Being mindful of your work-life balance could also go a long way in helping to minimise stress. In the New Scientist in January this year they published a new report stating: "The largest ever analysis of working hours and alcohol consumption has found that people who work over 48 hours a week drink more than people with standard working weeks. Marianna Virtanen at the Finnish Institute of Occupational Health in Helsinki and her colleagues pulled together data about more than 330,000 people from 14 countries, including the US, UK and Germany."[8]

Mindful of the dento-legal implications of uncontrolled alcohol use within the profession, Dental Protection outlined the importance of this in its 2014 Annual Review, maintaining that: "There is not much doubt that a healthy practitioner will be in a better position to look after the interests of patients than one whose health is compromised – for whatever reason." The article in the Review went on to say that "Drug dependency or addiction frequently compromises the ability to function at a high level and it is well recognised that the two agents that most commonly impact upon the ability of members of the dental team to practise are alcohol and drugs."[9]

The latest science

As well as being a regular feature in the national news with issues such "alcohol abuse costing the NHS £3.8bn a year"; the fact that "one in three of all A&E admissions are alcohol related"; and that "dentists should screen patients for alcohol abuse".[10]

If you read the New Scientist you will see they also regularly report on studies investigating the effects of alcohol on our bodies, as well as scientists working to try to find ways to combat it's harm. At the end of last year, the New Scientist reported that, "a patent application was filed for a drug that is supposed to give people a pleasant intoxication as well as limit the amount they drink." This new drug, given the name "chaperon" still has to go through detailed tests to establish how safe it is, as well how it could be used in practice, before it is available for general release[11].

In January this year they also reported on another study that, for the first time, looked at the effects alcohol had on our immune systems. The scientists undertaking the study found that "At first, the immune system ramps up, but within a few hours there is an anti-inflammatory phase during which its responses are weakened....if binge drinking can start affecting a person's immune system – and the way they respond to illness or injury – within an hour, doctors should take this into account."[12] So it appears to be a subject that is always heavily in the press.

As you and your colleagues enjoy a relaxing glass (or two) after a hard day at work, with the sun streaming through the trees, perhaps you should think about finding a way to ensure that alcohol doesn't become a coping mechanism for stress, now or in your future career.

[5] https://www.bda.org/search-results?k=Oral%20Health%20Inequalities%20Policy

[6] http://www.cancerresearchuk.org/about-cancer/causes-of-cancer/alcohol-and-cancer/alcohol-facts-and-evidence#alcohol_facts0

[7] www.joanna-taylor.co.uk/stress-in-the-dental-practice.html#.VDai9EuFb1o

[8] http://www.newscientist.com/article/mg22530043.900-long-hours-make-people-more-likely-to-drink-heavily.html#.VUC6DCFVhHw

[9] http://www.dentalprotection.org/docs/librariesprovider4/dpl-publications/annual-review-2014.pdf?sfvrsn=6

[10] http://www.bbc.co.uk/news/health-32418122

[11] http://www.newscientist.com/article/mg22530022.900-high-and-dry-party-drug-could-target-excess-drinking.html#.VUDlCiFVhHw

[12] http://www.newscientist.com/article/mg22530031.800-booze-binge-has-immediate-effect-on-immune-system.html#.VUC6PSFVhHw

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