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Full UK £162 | Digital Subscription £125
Retired GDP £89
Student UK Full £50 | Foundation Year £70
11 issues per year
Single copies £24 (NON UK £35)
Subscriptions cannot be refunded

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DU ISSN 0305-5000

Trevor Burke

Dental Olympians 2021

Olympian – person of great attainment.[1]

The pandemic has taught us many things, but one that is highlighted in my mind is that it is foolhardy to try to plan anything too far into the future. The same applies to the Tokyo Olympics, given, as I write, there are still murmurings about the sense of holding these, even one year late, in view of the rapid rise in the Delta COVID variant.

I have reminisced about dental Olympians during previous games, mentioning, among others, the move away from destructive dentistry, bemoaning the lack of impetus on water fluoridation (2008), the rise and rise of dental implants, the coming of age of zirconia, the fact that 'enamel is not a renewable resource' with Martin Kelleher at the helm as a true dental Olympian in that discussion (2012), the arrival of peri-implantitis and the contributions of Olympians such as Kevin Lewis and the late Jimmy Steele, plus the work on perio-systemic links in 2016.

However, in the year 2021, the dental Olympian emphasis must necessarily relate to the pandemic, since this is an event that has changed the lives of everyone. The UK dental profession was shut down in March 2020, and, apart from facing the resulting financial hardship, it also faced a serious shortfall in CPD. In the style of a true dental Olympian, Louis MacKenzie, a member of the Editorial Board of *Dental Update*, asked members of the Board if they would contribute to a series of webinars. As a result, he launched these in short time, and, by the end, more than 90,000 dentists had registered for the webinars, keeping them in touch with dentistry while they were not able to work. He has since gone on to organize other series (another 92,000 registered for those), especially in his new role of Head Dentist at Denplan. He is the ultimate dental impresario! In that regard, webinars, rather than 'live' lectures, are something that I feel are now with us to stay. Organizers of courses will surely have realized that it is more cost effective to pay me the same amount for a webinar addressing 1000 people than for a 'live' lecture to 100! Even if they cannot be sure that all of the webinar attendees are actually listening!

Notwithstanding Louis' contribution, the true dental Olympians in 2021 must be the general dentists who have laboured under the enormous pressure of cumbersome PPE when carrying out procedures that involve an aerosol. This has led to a great shortfall in productivity, especially when one recalls that procedures within the General Dental Services (such as crowns), which are awarded the maximum score of 12 Units of Dental Activity (UDAs), inevitably require a turbine/aerosol. Notwithstanding the fact that it has been estimated that *circa* half of dental procedures do not require an aerosol,[2] and that I, and co-authors,[3] have outlined the variety of procedures that can, therefore, be completed without an aerosol, so aptly described by Sharif Islam[4] as 'aerosol avoidance'. It seems that the adoption of this is only slowly beginning to dawn.[4]

I mentioned UDAs in 2012, writing that 'NHS practitioners have endured a system that few like (other than government) and in which there is scant knowledge and little check on the treatments that are being carried out'. Nothing has changed. By 2016, I wrote that NHS dentists had continued to work within a grossly unsuitable system, to which they have adapted to some degree. Still, nothing changed. At least, today, the Welsh government has realized the unsuitability of the UDA system and has abandoned it. The noise from NHS England on this has not been deafening. I realize that the NHS has had much greater difficulties to deal with than keeping NHS dentistry afloat, but dentists are feeling abandoned by the lack of information regarding their future.

Road map seems to be a popular term just now: what dentists now need is a clear road map on how dental practices will return to normal. What therefore is needed is clarity on whether aerosols do actually pose a real, rather than theoretical, hazard, and, if NHS England had had

the best interests of its dentists (indeed all dentists NHS and private) at heart they would have commissioned urgently needed research into this a year ago. And also, launched a media campaign advising the public that a visit to a dental practice was, as it always has been, as safe a place that they could choose to visit, much safer than visiting the local corner shop.

So, if I can look at the aerosol problem in a simplistic way (that's my style!), may I suggest two possible solutions by which GDPs' lives can be improved. If there could be clarity regarding the risks of dental aerosols, then there is a chance of a return to pre-pandemic 'normality', much as many orthodontic practices (not using an aerosol) have done. With increasing numbers of the public in the UK having received their second vaccine, surely the risk of COVID transmission in a dental surgery is at an all-time low? Another way of solving the decontamination problem is to introduce rapid tests for COVID, such as LAMP (loop-mediated isothermal amplification) and LamPore, which are at an advanced stage of development and testing. Unlike PCR tests, LAMP tests can turnaround test results rapidly. These are similar to PCR tests, but they use another method to amplify the genetic material in your sample, which is faster and cheaper than PCR and does not require a laboratory. LamPORE tests combine LAMP with rapid, portable DNA sequencing to detect COVID-19 genetic material. LAMP testing has a sensitivity of 79%, but the LamPORE test is up to 99.6%, making it extremely accurate at diagnosing positive COVID cases. I first learned about these three months back when listening to a webinar by Professor Lakshman Samaranayake, so I am delighted that he has addressed the subject of point-of-care testing in his latest COVID-19 Commentary.[5]

As a result of the wide variety of hassles involving working in dental practice, the pandemic had added substantially to practitioners' workloads. In that regard, there is now widespread disquiet among the dental profession, with rumours of NHS dental contracts being returned as a result of the targets imposed by those who have never worked in dental practice and dentists indicating that, if they could, they would leave the profession.[6] In this regard, 61% of principal dentists in England indicated 'strongly agree' or 'agree' to the question 'I often think about leaving general dental practice', the figure rising to 75% in Wales. The equivalent figure for associates was five percentage points less than for principals, with the figures having risen *circa* 6% since 2015. External regulations (which included GDC, practice inspection and decontamination) and rising expenses/diminishing income were factors in poor morale. No wonder that there are now over 11,000 signatories (and rising as I write) to a petition calling for (another) independent review of the existing contract and a rethink on how dental services are delivered.[7]

So, while other factors, such as fear of litigation, recruitment and retention issues will remain for all dentists, removal of the need for cumbersome PPE (not to mention its cost) and a return to 'normal' working when using a turbine would seem to be a major step in helping to retain the dental workforce in these difficult times. It would be a great shame, indeed, a scandal, to lose any of the true dental Olympian GDPs upon whom their public depends.

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