In the British Homeopathic Association and Faculty of Homeopathy's first *viewpoint*, **SUE FARRER** discusses the role of integrative medicine in dental healthcare...

INTEGRATIVE medicine combines conventional and complementary medical treatments, which have some proof of efficacy. This holistic paradigm has been employed all over the world for centuries and continues to thrive.

Today in America, 42 per cent of hospitals offer one or more complementary therapies, including homeopathy, which reinforces the fact that patients are demanding both conventional and complementary medicine.[1]

The UK complementary medicine market was reported to be worth £213m in 2009, an increase of 18 per cent since 2007. Despite legislative changes, 12 million people in the UK used complementary medicine or therapies in 2009, including herbal, naturopathic, nutritional and homeopathic medicines.[2]

So, who uses homeopathy? NHS homeopathic hospitals and clinics; veterinary surgeons and the farming community; and, more than likely, so do many of your patients. Today's patient has better access to health information and demands personalised healthcare. I receive patient enquiries daily, requesting access to a homeopathically trained dentist.

Dentistry is largely mechanistic, with therapeutics playing a small part in treatment planning. However, there are clinical scenarios where conventional approaches fail to achieve homeostasis e.g. chronic infection, prolonged post-operative healing, periodontal conditions, oral ulceration, sinusitis and anxiety syndromes, all of which provide an opportunity to embrace homeopathic medicine as part of the dentist's "tool kit".

Homeopathy has been used for over 200 years. It is based on the principles of "like cures like" and the "minimum dose" delivered in natural, multicomponent, low concentrations, to support the healing response.

It remains popular in Europe, particularly in Italy, where 45 per cent of medical doctors integrate this system into everyday practice.[3] However, in the UK, populist critics in the media have aggressively attacked the use of homeopathic medicine to the extent that serious intellectual debate has been stifled.

There is, nonetheless, growing evidence supporting the validity of homeopathy. Current research databases include 156 RCTs in homeopathy; where 41 per cent have shown positive results, while only 7 per cent have been negative. The others were non-conclusive. Four out of five systematic reviews have also returned broadly positive results. Furthermore, clinical observational studies continually show high levels of patient satisfaction.[4]

The latest in-vivo human study on haemodynamic responses to the administration of homeopathic medicines, demonstrates the ability to objectively record these responses.[5] Although research into dental homeopathy is limited, it is an area that is beginning to attract interest and two dental homeopathy papers, yielding positive results, have been recently submitted to peer-reviewed journals for UK publication. ■

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Introducing **KEVIN O'BRIEN**, Chair of the General Dental Council...

I BECAME Chair of the General Dental Council in September last year, and I would like to start by saying how pleased and honoured I am to have been elected by the members of the Council to this important role.

We are committed to continually improving the way we work to ensure that standards in dentistry are maintained for the benefit of patients.

Everyone at the GDC is aware of the current challenges it faces, and members of the Council, and staff in the Executive, are all working hard to address them.

One of our primary aims is to make improvements to our Fitness to Practise (FtP) processes, and we have already made inroads on the backlog of cases.

As you may have already read, we have approved several methods of improving the initial triage of complaints, including early involvement of clinical expertise. We intend that this will result in a reduction of cases going to the Investigating Committee. These changes have been well thought through, and have already begun to address the issues identified in performance reports from the Council for Healthcare Regulatory Excellence (CHRE).

In an audit published in September 2011, it stated: "We are confident that the GDC is now aware of the work it needs to do to achieve the necessary improvements to its FtP processes, and that it has plans in place to achieve those improvements within a reasonable timescale."

We're also reviewing our Standards, our Scope of Practice document and our continuing professional development scheme. In addition, important development work continues on a scheme of revalidation for dentists. We are taking a range of steps to ensure that registrants have a full say in shaping any changes that may emerge from these key pieces of work. I encourage you all to take these opportunities as they come along.

In addition, we are also developing a new approach to quality assuring dental education; based on assessing learning outcomes rather than training inputs. Implementing a new curriculum for all groups of pre-registration students, and starting a new round of inspections of the UK's Dental Schools, are big tasks, but I am very confident that we will succeed.

All of this work has had financial implications, but due to some difficult decisions about the Annual Retention Fee (ARF) last year, we have been able to keep it on hold for 2012. Despite some claims to the contrary, this was not a decision forced upon us by the Government. There was no legislation to prevent a rise.

The Government released a Command paper, Enabling Excellence – Autonomy and Accountability for Health and Social Care Staff *in February, which stated:* "the Government would not expect registration fees to increase beyond their current levels, unless there is a clear and robust business case that any increase is essential to ensure the exercise of statutory duties."

The decision to keep the ARF at the current level for 2012 was therefore made by the GDC. When we raised the fee last year, it was certainly in my mind that we would not be making substantial increases this year.

I am confident that we will make great changes over the next few years with a view to becoming a leader in healthcare regulation. But, I would also highlight that the decisions we make will impact upon you, therefore it's important to take part in our consultations and research. This way, your voices will be heard and we can make strong, relevant, evidence-based policies. ■

Why we should always mind the gaps, by **MICHAEL SULTAN**, clinical director of EndoCare...

MISSING teeth are disturbing. Unsightly gaps change an attractive face into something absurd and almost menacing, as every child who's ever blacked out the teeth of a face in a photo knows. In comic books, cartoons and films, "baddies" or thugs are often depicted with missing teeth, and, even as a dentist, the sight of someone outside of my surgery with teeth missing is unsettling.

In 1968, when the first Adult Dental Health Survey *was conducted, 37 per cent of the adult population was edentate. 40 years later, that figure has fallen to one in 16[1] and improvements in oral health have generally been impressive. Perhaps this is why I was so shocked to recently see people being vox-popped on TV with teeth missing. Maybe, I pondered, their adhesive bridge had debonded or they were waiting for their implant to integrate? Or not. Or maybe because they couldn't afford an alternative to extraction?*

Endodontists, like me, spend a great deal of time, energy and ink expounding the benefits of endo over implants; and treatment and retention versus extraction and replacement. Clinicians and specialists debate the relative merits of this treatment or that treatment, and the latest developments in technique, materials and equipment. However, I can't help but wonder whether we need to take a step back now and again, and consider the right to maintain teeth.

If Miguel de Cervantes' Don Quixote is correct, in that: "Every tooth in a man's head is more valuable than a diamond", *then how can we, as caring, ethical health professionals, accept that patients may opt for an extraction for purely financial reasons? How can we possibly take pride in ourselves and our work if we would willingly extract an upper central incisor and let the patient walk out into the street? Isn't the option to retreat later, better than a tooth in a bucket?*

Of course, those may be simplistic observations, but it is worth looking more closely at the latest 10-year Adult Dental Health Survey[2], *which studied 13,400 households in England, Wales and Northern Ireland. People are retaining their natural teeth longer.*

The idea that more than half of those aged 85 or more would still have some of their own teeth would have been simply unthinkable in 1968. For people under 45, and particularly young adults aged 16-24, the chances of retaining a considerable number of healthy teeth are high. However, for those aged over 45, the legacy of less effective dental care and higher disease levels in their early years is evident in fewer natural teeth and fewer sound teeth.

The link between poor oral and general health is beyond doubt, and while there is much to cheer about in the ADHS, *which shows extensive overall improvement and greater awareness of the importance of good oral healthcare, there is also no room for complacency. Inequality persists across the UK, and the same survey indicated that one in five people have put off visiting a dentist because of cost.[3]*

Clearly, greater retention of natural teeth is to be welcomed. But, with little sunshine on the economic horizon, we need to be aware of the potential increase in people who cannot afford to have treatment and opt for extraction. It would be a terrible indictment of our profession if we were to turn the clock back to the days of pulling teeth for the poor and only treating the rich. ■

References

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