Letters to the Editor

Send your letters to the Editor, British Dental Journal, 64 Wimpole Street, London, W1G 8YS
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Priority will be given to letters less than 500 words long. Authors must sign the letter, which may be edited for reasons of space.

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UNJUST, RELATIVELY IGNORED

Sir, how refreshing to read A. Holden's paper *Public opinion* in the *BDJ* (2013; **214:** 383–385). What an enlightened young GDP. As a GDP and visiting Professor of Community General Dental Practice at the University of South Wales I was totally in tune with his opening statements, particularly: '...I like dental public health. My friends and colleagues (GDPs) give me a strange look when I tell them this.'

The paper informs the reader that the oral health problem is presently social inequality, a reality which many GDPs are aware of but in reality is it their problem? The question is do GDPs have a role in addressing social inequality? Do GDPs treat populations or individuals?

Dr Holden clearly describes the barriers that individuals from deprived populations have in order for them to choose healthy pathways.

He then identifies that his FD1 training omitted community dentistry implying that these aspects of training were unimportant compared with other clinical hands-on specialities. As a recent trainer of FD1s I agree with his sentiments.

If GDPs are to have a role in addressing social inequalities in oral health then clearly they need to be equipped with the tools to help them do this and they need to be rewarded for their actions. The pilots for developing new contracts for GDPs may address appropriate rewards. However, there is little in the narrative in how to influence behaviour change, particularly with regard to individuals from disadvantaged groups becoming regular attenders. There is almost a 'hidden' assumption that these individuals do not want this pathway.

In order to facilitate change with individual patients the skills of health behaviour change (HBC) need to be identified, acquired and practised by GDPs and their teams. One key skill is that of motivational interviewing (MI).[1-3] MI is based on autonomous collaborative relationships in which the leader (GDP) values the four principles of empathy, self-efficacy, discrepancy and 'rolling with resistance'. I take no responsibility to further expand here and understand if readers feel frustrated but this possibly demonstrates the need for training.

Dr Holden is correct in identifying that the social determinants of health are beyond the individual practitioner but he does say that the dental profession should not rest upon their laurels because of the observed improvement in population oral health. The improvement means that the gap between the best and worse is wider and this situation is unjust and relatively ignored.

When we know that caries and periodontal disease are preventable for most individuals it is particularly unjust if disadvantaged groups are not able to access appropriate dental care. While appropriate care does not mean emergency treatment at an access centre, a care pathway underpinned on the principles of HBC and MI may facilitate better health outcomes for this sub-group.

Ignoring the wider influences that affect oral health in society could generate a negative public opinion of dentists. Treating individuals in the surgery in the context of an understanding of disease distribution in the population and applying HBC modalities is likely to generate a positive public opinion of dentists.

Before an appreciation of the reality of the social determinants of health can be achieved, as Dr Holden states, greater support for dental public health theory is required by the dental profession. Then the principles can be transferred into practice, particularly the skills of HBC.

W. Richards
By email

1. Mason P, Butler C C. *Health Behaviour Change: a guide for practitioners.* Churchill Livingstone Elsevier, 2010.
2. Ramsier C A, Survan J E. *Health behaviour change in the dental practice.* Wiley-Blackwell, 2010.
3. Richards W. Patient-centred dental practice: a behavioural approach. *Dent Nursing* 2010; **8:** 443–447.

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NEEDLESS NEEDLE LOSS

Sir, we would like to bring this case report to the attention of your readers as a timely reminder to them of the small but significant risk of needle breakage during inferior alveolar nerve block. This has serious implications for the patient and practitioner.[1]

A 62-year-old male was referred to the local maxillofacial team by his dentist following the breakage of a dental needle in the pterygomandibular space while administering an inferior alveolar nerve block. Plain radiographs showed the presence of the needle high in the ramus.

The needle was electively removed under general anaesthesia. Surgical exploration of the pterygomandibular space was carried out with the aid of image intensification in theatre[2] and the needle was found positioned medial to the lingual nerve (Fig. 1). Recovery was uneventful.

Although needle breakage is rare, it can and does occur. Evidence shows breakage is most common during administration of an inferior alveolar nerve block with a short 30-gauge needle.[3]

Prompt referral to the maxillofacial team is essential due to the risk of needle