LETTERS TO THE EDITOR

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ERRATUM

Letter *Br Dent J* 2015; **219:** 48

'Case reports: Giant sialolith

In the above letter we stated the author was Sabit Demircan from Istanbul, Turkey. The letter's co-author, Sabri Işler from Istanbul, Turkey, was omitted in error.

We apologise for any inconvenience caused.

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ETHICS

Assessing 'material risk' and 'values'

Sir, the authors have drilled into the landmark case of Montgomery (Appellant) *v* Lanarkshire Health Board (Respondent) (Scotland) The Supreme Court. Hilary Term [2015] UKSC 11 On appeal from: [2013] CSIH 3; [2010] CSIH 104), recently heard by their Lordships (*Br Dent J* 2015; **219:** 57–59).

As they state, there is agreement between the ethical codes advised by the General Dental Council (in *Standards for the dental team* and in particular the earlier GDC guidance *Principles of patient consent*) and the General Medical Council, and this Supreme Court judgement. But how can a dentist assess 'material risk' and the 'values' a patient ascribes to that particular treatment?

An approach has been described by Shokrollahi (*Ann R Coll Surg Engl* 2010; **92:** 93–100), that has been summarised in this Journal's abstracts section (*Br Dent J* DOI: 10.1038/sj.bdj.2010.541). In this, the patient is invited to complete a request for treatment form. In carrying this out 1) the practitioner shares information with the patient as to the benefits and risks of the procedure, 2) the patient is then asked to put down in their own words on the request for treatment form what they have understood by the discussion, 3) the patient is invited to state their decision, and finally, 4) affirms this by the customary 'symbolic signature'. In addition, completing a request for treatment form is a 'soft' method (for the practitioner) of assessing capacity.

The completed request for treatment form is filed in the case-notes as evidence of valid consent.

Request for treatment forms are available for download from www.rft.org.uk.

H. Beckett, London
J. Radford, Dundee

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TECHNOLOGY

Generation theory in practice

Sir, I first realised I was looking a little older at a recent dental trade show. A salesman was explaining the function of the app he was promoting. Clearly frustrated by my apparent lack of understanding, he closed the conversation with 'You could always get your kids to download it for you, sir'.

Plangger *et al.*[1] in their recent paper in the *BDJ*, state that 'smart mobile device apps ...are important tools to add to the dental patient experience'. However, my age group, described as baby boomers, have been shown to be slow to take up smartphone technology. Only 40% of us own a smartphone and around 33% of those has never used it to connect to the Internet or download an app[2]. We are also the heavy metal generation who will be prolific users of dental services over the next few decades.

I do not deny the importance of technological innovation in dental practice management. However, I suggest that the presence of a patient-facing app is unlikely to be the deal sealer for my generation when selecting a dental practice, not least because our children may well be living in Kathmandu or Cape Town.

P. Hellyer, Southsea

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COCHLEAR IMPLANT UPDATE

Sir, I respond to the Letter *Patient safety: Cochlear implants*.[1] In dentistry monopolar electrosurgery is more often used than bipolar for aesthetic and restorative purposes,[2] but monopolar instruments are contraindicated in patients with cochlear implants.[2-4] If bipolar electrosurgical instruments are used, the tip of the cautery should be at least 3 cm away from the implant location.[4] Monopolar diathermy should not be performed in the head and neck region and bipolar diathermy is contraindicated in sites within 2 cm of the cochlear implant.[5]

Dentists should never use microwave diathermy, shortwave diathermy and ultrasound diathermy on these implant patients.[6] These procedures may irreversibly damage the cochlear implant and neurons of inner ear.[5] Transcutaneous electrical nerve stimulation (TENS) therapy is used as one modality to treat TMJ pain[7] but should not be used in patients with a cochlear implant.[6] External parts of the implant should be removed when ultrasound tooth cleaning machines are used.[6] Ultrasonic imaging and therapy is contraindicated in these patients.[4] The speech processor of the cochlear implant should be switched off, removed and kept away from the room containing X-ray equipment while taking dental radiographs.[6] Patients with Nucleus 24 cochlear implants can undergo a magnetic resonance imaging (MRI) scan up to 1.5 Tesla by using a splint and head bandage.[8] A recent study observed that an MRI scan can cause pain, magnet displacement, and polarity reversal of the magnet and surgery may be required for removal and reinsertion of the magnet.[9] External components of the implant should be removed during MRI scans, gamma camera and radiotherapy with cobalt units/linear accelerator.[4,6] Patients' cochlear implant teams should be consulted before these procedures. Cone beam computed tomography, computed tomography, electric pulp test, panoramic radiograph and digital radiograph are quite safe in these patients.

V. Kumar,
India

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DENTAL EDUCATION

Why introducing implementation science and stakeholder engagement belong in evidence-based dental education

Sir, in previous publications, we described aspects of our approach to developing an evidence-based dental curriculum.[1,2] In addition to teaching our dental students the fundamentals of epidemiology and observational study design, we are also providing exposure to our students on how to interpret and assess the quality of systematic reviews and meta-analyses, and introducing them to newer methodologies including the use of decision aids and patient-reported outcomes. It is important for dental students to be introduced to these emerging methods in other healthcare professions, such as medicine and nursing, as familiarity with these newer methods will prove beneficial in an era of increasing inter-professional collaboration.

Implementation science studies the use of strategies to adapt and use evidence-based interventions (EBIs) in targeted settings such as schools, workplaces, healthcare facilities and public health departments to sustain improvements to population health.[3] Investments in basic and clinical research can be wasted if effective clinical or preventive models are not applied in practice.[4] Evidence indicates that only about half of the available medical and public health innovations are currently used in practice but there are sufficient EBIs to reduce by more than 50% the burden of cancer, chronic and infectious diseases in the United States.[3] Implementation science does not necessarily use specific research methods but can include a broad range of traditional research approaches such as randomised trials, qualitative methods, systematic reviews and economic modelling. Most of the studies on implementation science in healthcare have focused on physicians and nurses but introducing dental students to the important aspects of implementation science, including stakeholder engagement, is crucial as the dental students of today are the dental researchers, practitioners and policymakers of tomorrow. To ensure that dental EBIs are implemented in the groups that need them most, including underserved populations, more involvement of other stakeholder groups besides scientists are needed and the opinions and expertise of policy and practice experts needs to be weighted more heavily.[3]

We increasingly talk about the need for ensuring dental students are competent in evidence-based methods and the importance of teaching proper methodological approaches but we should also be teaching students what it means to engage with stakeholders and encouraging them to also consider careers that involve helping to make policy.

B. Laurence, Washington, USA

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GRADUATES

Know the law

Sir, I refer to the article 'Perception of studying dental law and ethics among postgraduate dental students in the UK' published in this Journal (*BDJ* 2015; 219:131–134).

I graduated, in 1993 having undertaken one of the first law and ethics in medicine courses in the UK at the University of Glasgow.

Unlike my experience of the BDS course, the law and ethics course required me to actually have to think about contentious issues and, at least try to, formulate an opinion about a broad range of 'medical', as opposed to specifically, 'dental' subjects mentioned in the article.

I firmly believe that a broad approach, including experience of such subjects, helps one to appreciate and better understand many areas of the subject such as patient autonomy, rights, consent etc.

A better understanding of the whole area must, of course, lead to better relationships between patient and clinician, but none of these issues, eg consent and confidentiality, is a 'stand alone' subject and, while not including the 'medical' topics may shorten a course, I consider that they should be included in order that the individual can develop a fuller awareness of the whole subject.

J. Pairman, Aberdeen

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ANTIBIOTIC RESISTANCE

Clearer guidelines needed

Sir, antibiotic resistance is a global problem and measures to research newer alternatives should be a priority as this poses a significant risk in the future. Each case should be considered carefully before prescribing antibiotics, and based on a correct diagnosis by appropriately trained staff. Some GPs and dentists may feel pressurised by patients who demand antibiotics as they feel it will make them better but clinicians should resist this and say no. There are new NICE guidelines on antibiotics.

It has been mooted that prescribers should be disciplined for over-prescribing which in my opinion is a ridiculous notion as this will be difficult to monitor and enforce. Both the GMC/RCN and GDC have clear standards expected from their registered members. I feel further threats to question clinical judgement could be detrimental and could lead to clinicians being over cautious and possibly doubt their own clinical diagnosis.

In my opinion, guidelines should consider a justification box within the FP10 prescription endorsement section. Recording a justification for giving antibiotics on the FP10 will help with audits on prescribing and could assist the pharmacist if there are issues with the prescription. Having a justification could also alert the pharmacist if they felt they needed to question the prescription, eg for a 'cold' or 'sinusitis' both self-limiting illnesses. It will require both clinicians and pharmacists to liaise closely together. Excellent teamwork and communication will be essential for both clinicians and pharmacists to ensure the best interests of the patients are met.

M. Parsons, Sheffield

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