LETTERS TO THE EDITOR

Send your letters to the Editor, British Dental Journal, 64 Wimpole Street, London, W1G 8YS
Email bdj@bda.org. Priority will be given to letters less than 500 words long. Authors must sign the letter, which may be edited for reasons of space. Readers may now comment on letters via the *BDJ* website (www.bdj.co.uk). A 'Readers' Comments' section appears at the end of the full text of each letter online.

SMOKING CESSATION

Out with the new and in with the old?

Sir, we are repeatedly prompted to urge our patients to give up smoking and I have found a delightfully decorous way that seems to work which I would like to share with your readers.

Bludgeoning our patients with yet more scientific reasons to quit meets a fairly stony resistance as they have probably heard it all before. Instead of using that confrontational approach I tried working with them, and this gentler approach seems to be more effective.

I find that many patients who are trying to quit are smoking about 15 cigarettes per day and need a bit of help to cut down further. Reaching for 'just one more' from the packet is all too easy and so I have got my patients to visit local charity shops to buy themselves an old cigarette case (hopefully of a suitable style for them as the fabulous Fabergé ones are so difficult to find these days!). They then put that day's quota (eg 15 cigarettes) into the case and that has to last them for the day – no more sneaking another quick one in.

This helps them to eek out a bit more time between their fixes of nicotine as they know that they have a self-imposed, limited supply for the whole day. Also, the process of counting them into the case works in the same way as popping pills out of blister packs makes one realise exactly how many pills one is dispensing. If by the end of the day they find that they have one or more left over, they could even give themselves a sticker on some chart inside the kitchen cupboard.

The following week, they put one less cigarette into the case and so on until they have been able to wean themselves off the dreaded weed completely.

This method is proving to be quite successful and I commend it to your readers to try with their own patients. The charity shops then benefit again by the patient taking the now-redundant cigarette case back for resale!

C. Marks, Southampton

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INFECTION CONTROL

Removing the sensation

Sir, it was interesting to read the letter to the editor in this Journal on gloves by J. Limeres, M. Diniz and P. Diz[1] and the original article, 'Glove wearing an assessment of evidence' also in the *British Dental Journal* by J Mew.[2]

Gloves are no different than condoms. They take the pleasure out of dentistry. Young people do not know anything better because they have never worked without gloves.

Specialisation in dentistry has increased because of loss of tactile sensation. The overall standard of dentistry has gone down. The number of gold and silver restorations has gone down because they require skill. The number of resin and glass-ionomer restorations has increased because these restorations are held in place by bonding techniques.

When the instruments are hot, gloves interfere with sense of touch and patients can be harmed. Because of lack of tactile sensation there is more chance of needle stick injury. The instruments and appliances like crowns and inlays can slip out of hand more easily while wearing gloves.

It is very difficult to use root canal instruments such as hand reamers and files with the gloves. Locating the apex while wearing gloves is very difficult. More and more patients are being referred to the specialist oral surgeons for extraction of teeth.

Recently there were headlines on the front page of *Sunday Express* dated 25 October, 2015, 'Fillings rot your teeth.' The original article on which the headlines were based was, 'Risk factors for caries development on tooth surfaces adjacent to newly placed class II composites – a practice based study'.[3] Most of the similar studies of damage to adjacent teeth have only been done since 1990. While preparing a class II cavity because of lack of tactile sensation while wearing gloves, it is easy to damage the adjacent tooth.

There was not a single study carried out comparing working with the gloves and working without the gloves.

L. K. Bandlish, London

1. Limeres J, Diniz M and Diz P. In practice: Glove wearing: new circumstances and many unknowns. *Br Dent J* 2015; **219:** 369.
2. Mew J. Glove wearing an assessment of evidence. *Br Dent J* 2015; **218**: 451–452.
3. Kopperud S E, Espelid I, Tveit A B and Skudutyte-Rysstad R. Risk factors for caries development on tooth surfaces adjacent to newly placed class II composites – a pragmatic, practice based study. *J Dent* 2015; **43**: 1323–1329.

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CASE REPORT

Plastic canal?

Sir, an interesting case is presented of a 34-year-old gentleman referred into the restorative department at The Royal London Dental Hospital. He presented with chronic periapical periodontitis around the previously root filled and post crowned 11, the crown was loose but could not easily be removed with finger pressure.

At assessment there was a discussion of what material the post was made out of as it appears relatively radiolucent (Fig. 1a). Upon removing the crown to begin re-root canal treatment it was discovered that the post was in fact a plastic burn-out post (Fig. 1b) and the core was largely a zinc oxide-eugenol-based material. This type of post is, of course, designed to be used to create an intra oral wax/resin post and core which can then be cast by a technician. The patient recalled that the post and

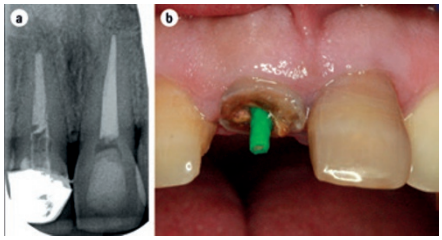

Fig. 1 (a) radiolucent post and (b) plastic burn-out post

crown had been made in London within the last 6 months and to his knowledge was meant to be permanent.

The post may have been designed to temporarily support the crown, allowing easier access for re-root canal treatment. Alternatively, the dentist who placed it may have been unaware of the purpose of the different post materials provided in a direct post kit, perhaps mistaking it for a composite-fibre post. It is important that a clinician is aware of the materials and the manufacturers intended use for them.

In this case the use of this post may have contributed to the leakage which resulted in the failure of this patient's initial endodontic treatment and was defiantly the cause of his crown becoming mobile.

M. James
London

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DENTAL EDUCATION

What are we going to do about it?

Sir, in the October edition of *BDJ in Practice* there is an article by Megan Atkinson – 'Oral surgery and the extraction crisis: What are we going to do about it?'[1] The article appears to claim that very little opportunity is given during training for students to extract teeth and to carry out surgical procedures and hence many graduates feel that they lack confidence, and ability when faced with patients requiring these type of treatments.

Since reading this article I have asked several people 'what are the three main skills they expect from a dentist?' Most state: a) to relieve pain, b) to be able to fill teeth, and c) to be able to extract teeth.

The GDC is the regulatory authority that is charged with ensuring that dentists are fit to practise, carrying out this role by agreeing the content and standard of undergraduate dental courses, prior to including a person on the register.

Those universities responsible for undergraduate dental courses must ensure that not only adequate teaching is given, but also that enough supervised practice of the procedures is carried out by the student to enable them to acquire the required skills and confidence.

It should also be that the supervisory staff should have the necessary skills, rather than just telling the student to refer the patient to hospital. I have had cases where the student has been told to refer the patient, by their supervisor, and the same student then successfully deal with the patient in clinic. When the university authorities are confident that the undergraduate is competent in the particular skill then they should be signed off, the GDC having agreed the level of competency necessary and the procedures necessary for qualification.

M. V. B. Nelson, via email

1. Atkinson M. Oral surgery and the extraction crisis: What are we going to do about it? *BDJ In Practice* 2015; (October) 8-9.

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GUIDANCE

Lost in translation

Sir, your reflections on subtle differences in the meaning of words caught our attention (Naming names, *Br Dent J* 2015; **219**: 6). In recent conversations with colleagues we have also noticed the term 'safeguarding' used, as you describe, in place of 'child protection'. You suggest that this is a development of language occurring with the passage of time. In part that is correct, but changing language does bring with it the potential for misuse and misinterpretation, particularly within complex multiprofessional fields.

'Child protection' and 'safeguarding' are not equivalent terms; there is an important distinction between the two, defined in the statutory guidance, *Working together to safeguard children*.[1] Their meanings have remained largely unchanged from earlier versions of the document[2] and since introduced to the dental profession in a widely-distributed Department of Health England commissioned learning resource in 2006.[3] Both terms refer to actions and interventions taken to prevent or respond to child abuse or neglect, not to refer to the actual abuse or neglect *per se*.

'Child protection' refers to the activity that is undertaken to protect specific children who are suffering, or are likely to suffer, significant harm whereas 'safeguarding and promoting the welfare of children' is defined as:

- Protecting children from maltreatment
- Preventing impairment of children's health or development
- Ensuring that children are growing up in circumstances consistent with the provision of safe and effective care
- Taking action to enable all children to have the best life chances.

Therefore child protection is just one part of a much wider agenda to safeguard and promote children's welfare. Child protection is the bit at the sharp end, when action is needed to keep children safe. Safeguarding includes child protection but also encompasses measures such as providing early help to vulnerable families.

The child protection literature laments that the system fails children because different groups of professionals work in silos and do not communicate effectively.[4,5] We wonder if we are developing a new dialect within our own silo rather than learning the nuances of the new language we need for effective inter-agency communication? If your readers have concerns that a child is at serious risk of harm because of abuse or neglect then we would urge them to use the term 'child protection' when they speak to social workers, otherwise there is a danger that their concerns will be lost in translation and result in an inadequate response. On the other hand, if they think a family needs further assessment to decide whether early help is needed for less serious concerns, then it would be entirely appropriate to talk about 'safeguarding' the child.

To the best of our knowledge this is currently the correct use of this language. It may of course change with the passage of time, as has related terminology: child abuse and neglect are increasingly referred to by the all-encompassing term 'child maltreatment'; social services are also now known as 'children's services' or 'children's social care'. In the meantime we hope the Journal will continue to publish pertinent papers on safeguarding children, both in its broader context, and more specifically around protecting children from abuse and neglect. This can only promote scholarship and debate in this important emerging field of dental practice, a field in which we all still have much to learn.

J. C. Harris, Sheffield
and P. D. Sidebotham, Warwick

1. Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children. London: Department for Education, HM Government 2015, publication no. DFE-00130-2015. pp 5, 15, 92. Available online at www.gov.uk/government/publications/working-together-to-safeguard-children--2 (accessed November 2015).
2. Department of Health, Home Office, Department for Education and Employment. Working Together to Safeguard Children. London: The Stationery Office, 1999.
3. Harris J, Sidebotham P, Welbury R, Townsend R, Green M, Goodwin J, Franklin C. Child Protection and the dental team: an introduction to safeguarding children in dental practice. p 51. Sheffield: Committee of Postgraduate Dental Deans and Directors (COPDEND) UK, 2006. www.cpdt.org.uk (accessed November 2015).
4. Brandon M, Sidebotham P, Bailey S, Belderson P, Hawley C, Ellis C, Megson M. New learning from serious case reviews: a two year report for 2009-2011. publication no. DFE-RR226. London: Department for Education, 2012.
5. Brandon M, Bailey S, Belderson P *et al*. Understanding serious case reviews and their impact. A biennial analysis of serious case reviews 2005-07. Publication no. DCSF-RR129. London: Department for Children, Schools and Families, 2009.

DOI: 10.1038/sj.bdj.2015.867