who was then one of the London trainees.

It should be noted that approximately four years ago the Chair of the Joint Committee for Postgraduate Training in Dentistry (JCPTD), Professor Jon Cowpe, established a small working group with the small cadre of clinical oral microbiologists remaining to see what could be achieved. JCPTD's membership includes representation from all stakeholders involved in dental education and training in the UK. A position paper was produced, which included a series of proposals. This was circulated widely along with discussions with key senior stakeholders in dentistry. Members of the group have continued to try to stimulate support for the specialty but unfortunately despite their best efforts, there continues to be no clear outcome.

I hope that in the light of the letter by Pankhurst *et al.* and my reply, this might stimulate senior colleagues in the NHS and academia to reconsider how best to take forward the need to train clinical microbiologists for the future.

C. Franklin, Sheffield

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A very big nut to crack

Sir, I read with interest the letter by Pankhurst *et al.* (*BDJ* 2016; **220:** 2–3) advocating the creation of more consultant oral microbiologists to 'provide a high calibre skills base...[to] modernise the surveillance of [antibiotic] drug resistance' as highlighted by the O'Neill report. This expanded group would mainly continue to 'oversee instrument decontamination and antibiotic stewardship' (presumably by educating and re-educating medical and dental professionals). On page 5 of the same issue in the *BDJ* in the 'News' section we learn that 'The rise of resistance to antibiotics is largely a consequence of human action and is as much a societal problem as a technological one' and the Economic and Social Research Council have recently been funded to look at this from the social science angle and raise awareness in that field.

This sounds a bit like climate change to me. We can all 'see' the problem, but vested interests, money and various other territorial and political standpoints will increase the numbers of related conferences and discussions exponentially but antibiotic resistance and over-prescribing will remain a very big nut to crack. I also read the other day that medical GPs' remuneration is partly based on 'patient satisfaction' – which could further muddy the water in the UK in respect of antibiotic prescribing.

Where does that leave us as humble UK dentists? So long as we continue to see patients who have been prescribed a course of antibiotics for a draining endodontic sinus then we must be prepared to admit that we have a problem. And that could be addressed by bypassing most of the above.

S. Jones, Newbury, Berkshire

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DENTAL EDUCATION

Too many graduates in India

Sir, gone are the days when the dental profession in India was considered elite and luxurious. The present scenario is very gloomy because of the greater number of dental graduates added each year (approximately 30,000)[1] to the already existing workforce without many career prospects. Presently 310 dental colleges exist in India[2] and the majority have an intake of 100 students per year. The bulk of the fresh dental graduates pursue the dream of a clinic, the next majority opts for postgraduate study, and a few aspire to clear the board requirements of a foreign country and become certified dentists.

A fledgling dentist in India has very limited scope to survive on his own immediately after graduation. The cut-throat competition among fellow dentists has escalated to unprecedented levels and a sense of insecurity seeps into fresh graduates. The recent threat to private practice is the rapid surge of corporate dentistry and the blistering pace at which they grow and multiply, making it almost impossible for a recent graduate to make an independent living. We conducted an informal survey among recent graduates and the majority (76%) reported working an average of ten hours per day even on weekends for 200 to 300 dollars a month and it appears as if new dental graduates are the most exploited workforce. The few who pursue postgraduate studies find it difficult to get into a specialty of their choice since only 3,000 seats exist.[3] Moreover, it's a trend among the of majority private institutions to levy huge capitations to procure admission and the scarcity of government college seats compel many to pay a fortune. Finally after postgraduation, they end up with the same career choice as an undergraduate because of the lack of new opportunities and 'survival of the fittest' competition. There seems absolutely no regulation by the dental council to limit the number of dental graduates and the level of unemployment increases because supply surpasses the demand. It is estimated that there will be a surplus of more than 100,000 dentists in India by 2020.[3]

The current scenario poses a serious threat to the professional integrity of fresh dental graduates and the percentage of dentists committing suicide is on the rise; the main reasons being unemployment and a sense of hopelessness.[4] It is high time for the dental council and government of India to take all necessary steps to improve the condition of dentistry and dentists of this nation before hope deteriorates completely.

Srinivasan Raj Samuel, Thai Moogambigai Dental College, India

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Student burnout

Sir, relatively few dental professionals or dental students are alert to the signs, symptoms, implications and best means to avoid burnout. In a study by Denton *et al.*[1] 18.5% of dentists were found to have existing or previous signs of burnout in two of the three diagnostic domains. Students are at just as much risk, with a recent survey of medical students reporting that one in three had experienced a mental health problem while at university.[2] Worryingly, more than 80% felt that the support for such issues at university was poor or moderately adequate.

Burnout is described as comprising three dimensions: increased emotional exhaustion – fatigue caused by the stress of work; increased depersonalisation, with the development of negative and cynical attitudes; and reduced levels of personal accomplishment, accompanied by feelings of diminishing competence and self-achievement. According to the systematic review by Singh *et al.*,[3] the risk factors for burnout in dental professionals are younger age, being male, certain personality types, participation in clinical degree programmes, long working hours and high levels of stress and responsibility.

The key to the management of burnout is early identification and prompt, effective intervention. Unfortunately, many individuals susceptible to and suffering from burnout work long hours under large amounts of stress, with little, if any time to recognise that they need help or seek support. Resting – taking time out, rather than just reducing working hours, is widely accepted as being an effective treatment.

Tackling burnout at the student level has many advantages in helping to equip

students with life skills, which they can carry into their professional career. Dental schools should, if they are not already doing so, adopt the following measures to reduce the incidence of burnout amongst their students:

1. Have realistic expectations of students in designing and revising the undergraduate curriculum to meet university and regulatory requirements
2. Educate students and staff on the risk factors, signs and symptoms of burnout
3. In the regular monitoring of students, pay special attention to assessing and identifying any signs and symptoms of burnout
4. Provide opportunity, and encourage students to develop a work-life balance, which enables them to maintain their endurance, energy and commitment.

Susceptibility to burnout may be measured using simple questionnaires: the 22-question MBI (healthcare specific format) or the 30-question ProQOL. Both require low student compliance being readily administered at, for example, the end of a lecture or clinical session. Keeping records of scores may help identify the possible onset of depersonalisation in individuals and the need to take action, possibly helping a student avoid burnout. Such scores may be used also by students for self-reflection on their work-life balance and the management of their studies. The major advantage is the empowering of the student to self-diagnose and manage any symptoms of burnout.

D. S. Aulak, B. Quinn, N. Wilson, by email

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ORTHODONTICS

Fast removal of claims

Sir, I think it worthwhile to bring to your readers' attention the result of an investigation by the Advertising Standards Agency (ASA) that was sparked, in part, by a previous discussion in these letters pages on the potential merits of Fastbraces.[1,2]

The ASA are a body funded by a levy on UK advertisers who take action against misleading, harmful or offensive advertisements. The ASA cannot investigate complaints on international websites. The main promotional Fastbraces website is not based in the UK.

I highlighted concerns I had about claims on a UK website relating to Fastbraces' efficacy and comparisons to other brace treatment (faster treatment, less painful treatment, less root resorption during treatment etc). I felt that these claims were unsubstantiated and misleading to potential patients. The ASA agreed to investigate whether 'the efficacy claims made for Fastbraces were misleading and could be substantiated'.

In a recent letter the ASA informed me that the website had agreed to remove such claims and that 'they will not appear again in the absence of adequate evidence'. As such, the issue was 'informally resolved'.

Given recent research into orthodontic practice websites published in this Journal that demonstrated generally poor compliance with GDC guidelines on ethical advertising,[3] this development serves to highlight the risks to colleagues (and patients) and challenges that can occur when manufacturers' claims are presented via a practitioner's own website.

Whilst I have no issues with the use of Fastbraces or any branded orthodontic appliances, if claims are advertised that a dentist (specialist or not) cannot legitimately back up, then it may not only be the ASA that takes umbrage, but also the GDC.

N. Stanford, by email

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DENTAL TRAUMA

Splinting with wire and composite

Sir, as clinicians at King's College Hospital and Board members of Dental Trauma UK we read the recent paper on avulsed permanent teeth with great interest and were a little surprised by the comments made subsequently by letter.[1,2]

In the letter the authors mention a number of aspects of the management of dental trauma and in particular the use of orthodontic brackets for splinting traumatised teeth.[2] Unfortunately, their notion that orthodontic brackets may be better than composite and wire splints for repositioning avulsed teeth is definitely not our experience, nor is it evidence based.

The letter asserts that the use of orthodontic brackets is the 'first choice' for both adult and paediatric patients in secondary care. We would disagree strongly with this, especially when considering the guidance in the dental trauma guide that the authors cited. In our opinion, orthodontic brackets are tricky to use especially by non-orthodontic specialists and most primary care practitioners are unlikely to have them readily at hand. Their