about half of the men would get to their feet. We have to ask by first and second name and even then sometimes have to fall back on nicknames. This is a rather special corner of Paradise in the Western Isles where we have a 12-surgery Health Board clinic (Western Isles Dental Centre). My colleagues are enthusiastic and funny, and compassionate. The patients have, to a large extent, retained a rather old-fashioned respect for professional people. They are understanding when we run late and appreciate the fact that we all try hard to provide a good service. Practising dentistry here is deeply satisfying.

N. Cole, by email

1. Coe J. First impressions. Meeting and greeting in the clinical setting – are we doing what patients want? *Br Dent J* 2017; **222:** 511.

DOI: 10.1038/sj.bdj.2017.432

OMFS

Mishandled Luxators

Sir, we read with interest Dr Shuttleworth's reflective letter on his surgical practice and the origins of the Luxator.[1] The same week the head nurse in our department brought to our attention six damaged Luxators returned by the sterile services department (Fig. 1).

Clearly these instruments have been abused and used as elevators with significant damage to the instruments in a relatively short time. This has prompted us to review the use of Luxators in our department. The vast majority of routine oral surgery/exodontia procedures has been and can be safely and effectively carried out with the additional use of conventional elevators. This can be in the form of Warwick James, Coupland's chisels and Cryer's elevators, which are routinely available in the MOS sets.

The senior author after three decades in oral surgery has adopted the use of Luxators in the last year for flapless atraumatic extractions preparatory for immediate implant placement. Luxators may be suitable for select cases of fractured roots or apices used carefully under direct vision and in a controlled and careful manner.

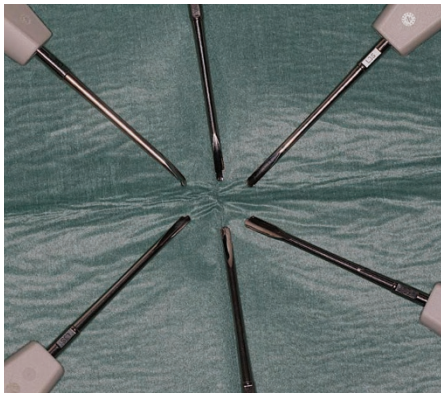

Fig. 1 Damaged mishandled Luxators

We would like to emphasise the cautious use of these sharp instruments as an adjunct in select MOS cases. It is advisable to use them with minimal pressure and appropriate finger rests to avoid any tissue damage when being applied in the periodontal space in case the instrument slips.

P. Parmar, A. Majumdar,
Beds Herts and Bucks Maxillofacial Network

1. Shuttleworth J. OMFS: My favourite instrument. *Br Dent J* 2017; **222:** 322.

DOI: 10.1038/sj.bdj.2017.433

Dental education

Reflective practitioners

Sir, as a current dental foundation trainee I was disappointed to read the article which expressed concern with 'declining standards' of trainees.[1] Although it may be true that we have had less clinical experience than our historical counterparts, I found it short-sighted that this was the only focus.

In this changing day of dentistry, and with the introduction of revalidation, the clinical component is only one of the four key domains. I feel that we are amid a new generation of dentists, and I do not agree that we are 'medico-legal centric', but rather we are focussed on developing in all four components for the benefit of our patients. Although some foundation trainees may have less experience with clinical procedures, the article failed to discuss other aspects key to foundation training. For example, in my training scheme we have received excellent feedback from our patient satisfaction questionnaires, completed multiple audits, and can self-identify our individual learning needs and create a personal development plan accordingly. It may also be valid to consider that clinical proficiency in a treatment such as crown and bridgework can be gained through experience in the general practice setting, whereas effective patient communication is a vital skill to acquire at the start of our careers. These other aspects contribute to us becoming well-rounded professionals and improve the standards of care for our patients. Overall, although I appreciate that the findings from this study do indicate a possible need to review undergraduate training, I think it is important to remember that clinical skill is only a quarter of the overall picture. I believe as current dental trainees we are developing into reflective practitioners and this is something that should be celebrated.

G. Kane, by email

1. Oxley C J, Dennick R, Batchelor P. The standard of newly qualified graduates – foundation trainer perceptions. *Br Dent J* 2017; **222:** 391–395.

DOI: 10.1038/sj.bdj.2017.434

Negative tone

Sir, the paper by Oxley, Dennick and Batchelor[1] presents our profession with some potentially challenging findings. Despite the limitations of this research, including how 'standards' were defined and any potential bias related to the poor return rate, we were disappointed by the negative tone of the discussion. Surely as a profession we should be delighted that so many of our new graduates are patient focused with good communication skills, with an emphasis on health prevention and professionalism.

As we educate final year students in an NHS primary care outreach setting, we are only just the other side of the divide between pre-qualification and foundation training. We have reported previously that students feel prepared for the challenges of qualification, NHS practice and DFT.[2] At the University of Portsmouth Dental Academy we do encourage the more advanced clinical skills of endodontics and crown and bridge, but with many patients on red and amber care plans these treatment modalities are often not appropriate to the frustration of both the students and their clinical teachers.

Our 'junior colleagues' need to leave undergraduate dental education after five years. Yes, they could gain more clinical experience, particularly in diagnosis and care planning, with additional time at dental school and in outreach situations, but surely this experience is the rationale for the provision of our well-funded foundation training. It is perhaps ironic, at a time when dental schools are increasingly making use of motivated, enthusiastic, part-time general dental practitioners to teach clinical skills to undergraduates, that a different group of general practitioners, the foundation trainees' educational supervisors, feel that those clinical skills are inadequate. As the educational supervisors are overseen by

COPDEND and the clinical teachers by dental schools, perhaps one solution to the alleged problem lies in improved communication between these two authorities.

In addition, we are aware that the significant majority of foundation trainers go far beyond the extra mile to professionally and clinically support and develop their foundation dentists. Therefore, it is essential that the funding formula for the educational supervisors is allocated appropriately so that our junior colleagues can continue to be well supported as they take their first steps in practice.

D. R. Radford, P. H. Hellyer, Portsmouth

1. Oxley C J, Dennick R, Batchelor P. The standard of newly qualified graduates – foundation trainer perceptions. *Br Dent J* 2017; **222:** 391–395.
2. Radford D R, Holmes S, Woolford M J, Dunne S M. The impact of integrated team care taught using a live NHS contract on the educational experience of final year dental students. *Br Dent J* 2014; **217:** 581–585.

DOI: 10.1038/sj.bdj.2017.435

Years of service

Full circle

Sir, I awaited the most recent issue of the *BDJ* and possible letters from others before applying for the record of longest serving dentist in the same practice!

This coming August I will have been at 'the Retreat' in Woking for 45 years – man and boy!

I remember as a first year clinical student marching on the Houses of Parliament in my 'White Coat' to protest at the introduction of NHS dental charges, using silicates for anterior fillings and the introduction of 'Adaptic' composite. I have over the years consigned buckets of 'the latest materials' to the bin but keen to try anything new, regarding all new techniques as potentially necessary to my professional advancement and worthy of consideration (if not action!).

Like your last long server, I too qualified from 'The London' and was taught 'Cons' by the late, great, Harry Allred who encouraged us to think about what we were doing, not follow blindly the 'Black' principles of cavity design, laying my foundation in minimal preparation dentistry and where appropriate minimum intervention. I was also lucky enough to have had Bernie Keiser as my perio tutor and Prof. Fish for prosthetics, Nicholls for endo and many other eminent tutors.

I know that evidence-based dentistry is now the norm, but regret the current tendency to disapprove of those who 'think outside the box'.

I have been in the enviable position of being able to see in the long term what works and what doesn't, but have come to the conclusion that most procedures if carried out diligently will work, and that all dentistry is the art of delaying tactics against the destroying hand of time!

I started as an associate in 1972, became a partner in 1974, moved mostly away from the NHS after the first 'new contract' around 1990 (seeing the writing on the wall), sold out to a corporate in 2001 and now full circle am working as an associate again!

I have had the good fortune to have worked in a very happy practice (apart from some years of the corporate), made a comfortable if not wealthy living, enjoying and feeling stimulated by dentistry and not least, feeling I have made a difference for my patients.

With the high costs of practice purchase, rise of the corporates and the downgrading of general dentistry from a profession to a business, I wonder what the chances are for new graduates to say the same and how many years they will enjoy and commit to dentistry.

T. Bradbury, by email

DOI: 10.1038/sj.bdj.2017.436

Mouth cancer

Craft beer craze

Sir, in the last decade, the emergence of independent breweries focusing on ales, stouts and flavoured beers, rather than lagers and bitters, has grown massively in the UK, as much as 65% in the last five years and 8% in 2016 alone. The UK now has well over 1,000 independent breweries.[1] This trend is not isolated to the UK, but can also be seen in the USA, Scandinavia and Southeast Asia.

The increase seen in frequency of consumption of high Alcohol By Volume (ABV) drinks in recent years may be of interest to us as clinicians given the group it appears to be affecting. The craft beer craze appears to be being embraced by younger people of higher socio-economic and educational background, both male and female. These patients have previously been seen as unlikely to suffer much in the way of dental and oral disease and possibly deemed overall 'low risk' patients.

As we get to grips with the relatively newly revealed increased risk of oral cancers through HPV transmission, I would draw attention to the risks associated with a possibly increasing consumption of high ABV drinks amongst a similar cohort of the population. These drinks are higher in alcohol content, with many exceeding 6% and reaching as high as 15%. The effect of this skews our previously held conceptions of units in a pint, possibly leading to missed 'red flags' in our medical and social history taking. As we are aware, the new NHS recommended intake for both men and women is now less than 14 units per week, spread across three days in the week.[2] In terms of an average 6% craft beer, this equates to only four pints per week, including weekends. This effect may also be seen, albeit to a lesser degree, in the increased consumption of often commercially cheaper 'New World' wines which are also higher in ABV. Furthermore, there is a well-documented, increased tendency towards consuming the weekly recommended allowance in one sitting.

The long-term effect of this pattern is obviously yet to be seen but as with all alcohol, there are definite immediate and cumulative risks in terms of trauma, oral cancer, non-carious tooth surface loss, and even periodontal disease.[3] What is possibly new, however, are the groups of patients this may be having an effect upon, and the responsibility we have to discuss this with them.[4] Finally, I would like to reinforce the risks to patients and our ourselves, of drinking alcohol the night before driving, working, or going into dental school.

J. B. White, by email

1. UHY. Number of UK breweries rises 8% in just a year as popularity of craft beer continues to soar. 3 October 2016. Available at: http://www.uhy-uk.com/news-events/news/number-of-uk-breweries-rises-8-in-just-a-year-as-popularity-of-craft-beer-continues-to-soar/ (accessed May 2017).
2. NHS choices. New alcohol advice issue. 8 January 2016. Available at: http://www.nhs.uk/news/2016/01January/Pages/New-alcohol-advice-issued.aspx (accessed May 2017).
3. Amaral Cda S, Vettore M V, Leão A. The relationship of alcohol dependence and alcohol consumption with periodontitis: a systematic review. *J Dent* 2009; **37:** 643–651.
4. Shepherd S, Young L, Clarkson J E, Bonetti D, Ogden G R. General dental practitioner views on providing alcohol related health advice; an exploratory study. *Br Dent J* 2010; **208:** E13.

DOI: 10.1038/ssj.bdj.2017.437