COMMENT

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.

Oral health

Learning styles

Sir, we may not be delivering oral hygiene instruction as effectively as possible. The majority of us attempt to educate our patients pedagogically; however, we must transition to the andragogical format of teaching to develop patients' knowledge and behaviour and ultimately improve patients' oral hygiene.

A learning style is defined as 'characteristic cognitive, effective, and psychosocial behaviours that serve as relatively stable indicators of how learners perceive, interact with, and respond to the learning environment'.[1] Basically, it is an individual's preferred method of learning.

The VARK classification describes learning styles by dividing individuals into learning characteristics by use of questionnaires: Visual (pictures, movies or diagrams), Auditory (music or discussion), Reading/Writing (lists, reading books or taking notes) and Kinaesthetic (experiments or hands-on activities) sensory modalities, giving a score for each separate modality.[2] It is recommended that we tailor the delivery of an individual's education to enhance learning based on this.

This has been used widely in dental education not to predominantly teach students in their preferred method but rather alter their delivery methods to give students with different learning styles a more conducive learning environment.[3] It has been shown that tailoring health information to patients with hypertension according to their literacy and learning preference will improve uptake of information and hopefully improve understanding and health.[4]

Although various methods of oral health education have been shown to be effective, one thing which is clear is that no one delivery method suits all patients.[5] Therefore, I wish to encourage us to personalise oral health education to the individual patient. For example, we could preferentially provide education in the form of a leaflet for patients in the reading sensory modality, deliver a more practical instruction for kinaesthetic patients and provide a more visual leaflet/video format for visual learners.

Doing a full questionnaire for every patient may not be practical; however, developing quicker techniques which would easily allow us to identify a patient's learning preference would allow us to adapt our delivery style.

C. P. Devine, by email

1. Curry L. Learning preferences and continuing medical education. *Can Med Assoc J* 1981; **124:** 535–536.
2. Fleming N D, Mills C. Not another inventory, rather a catalyst for reflection. To Improve *The Academy* 1992; **11:** 137–155.
3. Murphy R J, Gray S A, Straja S R, Bogert M C. Student learning preferences and teaching implications. *J Dent Educ* 2004; **68:** 859–866.
4. Giuse N B, Koonce T Y, Storrow A B, Kusnoor S V, Ye F. Using health literacy and learning style preferences to optimize the delivery of health information. *J Health Commun* 2012; **17(Supp 3):** 122–140.
5. Yoder M E. Preferred learning style and educational technology: linear vs. interactive video. *Nurs Health Care* 1994; **15:** 128–132.

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You're on camera

Sir, I think I speak for many when I say most of our patients could improve their oral hygiene. No matter how much we tell them, still they return at their next check up having never picked up an interdental brush, with that red band of inflamed gingivae hugging calculus and soft plaque deposits. So instead of telling them, why not show them?

Clinical photography is a great aid many are not using; I have found it to be key in engaging and motivating patients. Showing patients and explaining what they see aims to educate and engage them. They are used to seeing pictures in the media of perfect clean teeth so why not take a picture of theirs to show them the difference rather than just being told 'you need to floss'?

Take a photograph at each check up for comparison. Has there been an improvement? If so, where? If not, why? Photographs act as a clinical record, which helps to document whether the patient is truly engaging with treatment. This allows the clinician to gauge the level of compliance, can be helpful for decision-making and can offer support in litigation, by being able to clearly and accurately document continually poor plaque control and lack of patient engagement.

Overall I feel photography is a powerful tool we have at our disposal for patient motivation, engagement and education. It is not just for 'before and afters' or our own egos.

N. Parten, by email

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Orthodontics

Making false promises

Sir, it is not uncommon for dental practitioners to see adolescent patients in whom there is either a developing or established malocclusion associated with a significant underlying skeletal discrepancy. This may result in any combination of a marked Class II or III incisor relationship, significant facial asymmetry, and/or problems in the vertical dimension leading to a deep overbite or anterior open bite. These conditions may prompt the practitioner, quite rightly, to refer the patient to a specialist orthodontist or directly to the consultant-led hospital service for advice and/or treatment. In some cases, orthognathic

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