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.

Dental careers

An excellent template

Sir, I write to commend the excellent opinion piece by Hassan and Nazar.[1] The description of such a reasoned approach to career planning should give younger colleagues an excellent template as they make their way into practice. Beyond the clear benefits described in respect of the particular experience in this case, the application of loss aversion reasoning as a process would serve the wider profession well.

Decisions are seldom clear cut and there are usually trade-offs to be made. Consideration of the long-term benefits and deferred gratification can often help to prioritise. I would encourage practitioners young and old to read this piece and apply the same approach to difficult life decisions.

P. Ward, London, UK

References

1. Al Hassan A, Nazar S. Dental core training for the future GDP: is it worth it? *Br Dent J* 2019; **226:** 484-485.

DOI:10.1038/s41415-019-0457-6

OMFS

Appropriate referring

Sir, it was very disappointing to read the letter from Dr Tajmehr. [1]

Firstly, 155 patients referred over a 12-month period equates to just under 13 per month or about 3-4 per week. Having worked for seven years in various oral and maxillofacial units, as well as many years in general practice, I do not think this is putting a 'significant strain on secondary care services'.

Secondly, it was reported that 'of the remaining 143 referrals, the majority of patients were diagnosed with potentially-malignant and premalignant conditions'. Thankfully, the primary care practitioners had the requisite education and training to refer these patients, who will have been reassured by the non-cancer diagnosis and subsequent review and monitoring of their lesion instigated after histological diagnosis.

Thirdly, it was reported that 'the rest had no abnormal findings at all'. The word 'abnormal' is poorly used in this context. Does the author mean that at histology the oral mucosa was normal in appearance or that there were no histological signs of dysplasia? Most experienced clinicians will have come across clinically suspicious lesions which turn out to be benign at histological examination. The point here is that clinical appearance does not always correlate with histological examination.

Fourthly, there is extensive postgraduate training available to dental practitioners, which most of my colleagues will avail themselves of, nowadays under the watchful eye of the GDC. However, I do not know how much education and training our hard-pressed medical colleagues receive either in the undergraduate or postgraduate field. Perhaps, this is an area Dr Tajmehr would care to research?

Finally, I would urge all my primary care colleagues to continue to refer any suspicious lesions through their locally-agreed pathway to the appropriate oral and maxillofacial unit. They will find that their secondary care colleagues will not judge them on the 'appropriateness of the referral' but will be grateful for putting patients' interests first.

A. J. Wight, Dundee, UK

References

1. Tajmehr N. Appropriateness of referrals on the suspected cancer referral pathway - a secondary care perspective. *Br Dent J* 2019; **226:** 539-540.

DOI: 10.1038/s41415-019-0480-7

New specialty?

Sir, is there a new specialty (maxillofacial) as your headline suggests in the article reporting a study on knife crime published in *The Surgeon* (*BDJ* 2019; **226:** 552)? The lead author in that article was a training oral and maxillofacial surgeon and another co-author a consultant cral and maxillofacial surgeon at King's College Hospital. I suspect many of the reported patients attending hospital were first seen by dentists who are debarred from sitting the Royal College examinations to obtain GDC specialty recognition (oral surgery) as described in your other article in that journal (*BDJ* 2019; **226:** 546). Give credit where credit is due and refer correctly to the specialty as oral and maxillofacial surgery. Otherwise why give precious space in our journal to an unrelated specialty that has published elsewhere?

G. D. Wood, Wirral, UK

DOI: 10.1038/s41415-019-0479-0

Inappropriate referring

Sir, one of the problems facing oral and maxillofacial surgery (OMFS) clinicians is the inappropriate method of referring patients by our primary care colleagues via other members of staff.

Many general dental practitioners (GDPs) will ask non-clinical members of staff, such as the practice manager or a receptionist, to ring the hospital to refer emergency patients. This is inappropriate for a number of reasons. First, these individuals do not have the clinical knowledge or experience to relay the appropriate information. Second, only the person who has assessed the patient will be able to answer key questions on the patient's current condition and the seriousness of the situation. Third, this method of referring often creates more inefficiency than if the GDP had called initially. These issues severely compromise patient care, specifically the ability of the OMFS team to provide informed advice or management for these patients.

Conversely, in my experience, general medical practitioners (GMPs) consistently refer patients to our team via telephone call directly. This allows us to make an informed decision regarding patient care and does not compromise safety or efficiency.

Is the difference between GMPs and GDPs due to differences in teaching on referring patients? Or due to GMPs' increased experience in referring patients? Either way, professional courtesy would suggest that all referrals should be via telephone call from the referring practitioner to the accepting clinician, not via a non-clinical intermediary.

H. Pugh, Chelmsford, UK

DOI: 10.1038/s41415-019-0478-1:

Green dentistry

The *BDJ* polywrap

Sir, could I request that the *BDJ* gives consideration to replacing the polythene packaging used to send the journal? The National Trust now send their magazine to members proudly emblazoned with the information: 'I AM 100% COMPOSTABLE AND CONTAIN POTATO STARCH'.

There would also be an opportunity to use this material to comply with HTM 01-05 and other legislation which introduced sealable pouches for most dental instruments. Assuming 10,000 dentists use, say, 20 pouches a day, there will be in excess of four million plastic sleeves, headrest covers and instrument pouches (most have plastic windows) to be disposed of annually.

R. Baker, Cardiff, UK

The Editor-in-Chief replies: thank you for your letter which reflects several that we have received in recent times on this subject. Springer Nature, who publish the BDJ *and the other* BDJ *Portfolio publications on behalf of the owners, the BDA, have strong and continually reviewed and updated environmental policies which are reflected across the Portfolio. This includes the use of acid-free, recyclable paper and the use of recyclable plastic wrapping. As indicated on the wrapper itself, together with the recyclable logo, the film can be included with, for example, plastic supermarket bags in appropriate recycling bins and we know that readers do undertake this.*

We continually review the materials we use and have researched oxodegradeable film, biodegradable film and compostable film (manufactured from potato starch or corn starch - as mentioned by our correspondents). Currently the latter are not the same cost as recyclable plastic but are between five and six times more expensive. Industry intelligence suggests that these prices are likely to fall in future and we will continue to monitor this in the delicate balance between costs and environmental considerations.

DOI: 10.1038/s41415-019-0477-2

LGBT+ recognition

Lack of understanding

Sir, I was very disappointed to read S. Worthington's letter in the recent issue of the *BDJ*.[1] I feel it shows a lack of understanding of the purpose of the rainbow lanyard. The purpose is to encourage inclusivity and help to break down barriers that some LGBT+ people feel in talking freely to health professionals. Use of the lanyard is not designed to be a political statement. As such it supports GDC Standards 2013 section 1.6.1: You must not discriminate against patients on the grounds of age, disability, gender reassignment, marriage and civil partnership pregnancy or maternity, race religion or belief, sex, or sexual orientation. It provides reassurance to LGBT+ staff and patients in the NHS that they will not be discriminated against.

If a lanyard were introduced to reassure staff and patients that they would not be discriminated against on the basis of race, I wonder if the writer would also refuse to where this on the grounds that it may cause distress to those who hold racist views?

L. Nichols, New Malden, UK

References

1. Worthington S. Why I refuse the rainbow lanyard. *Br Dent J* 2019; **226:** 635-636.

DOI:

Oral health

'Natural' toothpastes

Sir, oral health care is a major concern for the general public and people are happy to spend extra dollars on oral hygiene. Toothpaste is a major consumer product for oral health and is used by all of us regularly.

However, there is a debate between fluoride and non-fluoride toothpaste with the market for fluoride-free toothpaste growing quickly.[1,2] A friend recently asked me an interesting question, being a consumer of natural toothpaste: 'why are natural toothpastes more expensive than fluoride based ones?'

I researched the market prices of natural/organic toothpaste, finding that that prices range from NZ$4.99-9.99 per 100 g, which is expensive for daily consumption. Further investigation showed that all of them have common ingredients in the formulation such as calcium carbonate, glycerol, menthol, xylitol, sodium bicarbonate, lauryl glucoside, carrageen, essential oils, xanthan gum and stevia, with few minor variances. As an experienced pharmacist and researcher, I decided to formulate my own natural toothpaste using the same ingredients to evaluate costing. This formulated toothpaste was around NZ$1.50 (0.76 GBP) per 100 g including packaging cost. Considering a 50% profit margin for the company with other expenses, the product price should stay at NZ$3.00 (1.50 GBP) per 100 g.

In summary, the purpose was not only to save a few dollars per tube but also to make dental professionals aware of the ridiculously high profit margins on natural oral care products of this type, so that they can pass on this useful information.

K. Patel, Auckland, New Zealand

References

1. McKay A. Organic toothpaste. *Br Dent J* 2012; **212:** 206.
2. Bartlett D, Smith B, Wilson R. Comparison of the effect of fluoride and non-fluoride toothpaste on tooth wear in vitro and the influence of enamel fluoride concentration and hardness of enamel. *Br Dent J* 1994; **176:** 346.

DOI: 10.1038/s41415-019-0475-4

Oral health education

Inconsistent approach in schools

Sir, it is disappointing to see the UK rank bottom in a global survey of oral health education in schools. Sadly, our experience indicates there is an inconsistent approach in schools to delivering oral health education and children are rarely taught about how to look after their own teeth. This is a serious missed opportunity to influence a child at an influential stage of their life. Teachers have told us they lack the knowledge and confidence to talk about the key oral health messages, and oral health does not feature prominently in key stages one and two of the national curriculum. As this survey reveals, we are falling behind in the global league table with many developing countries outperforming the UK.

This is something we have been aware of in Plymouth, UK, where schools have requested more support in delivering oral health education. In response, we have developed a