I have been subjected to such behaviour over several years which has impacted greatly on my health and wellbeing with regards to deterioration of a chronic health condition and the psychological impact of going through years of trying to have my genuine concerns heard, and acted upon appropriately. I eventually have had no choice but to leave the dental profession due to isolation, incivility, disrespect, harassment and bullying from colleagues, management and human resources.

Additionally, despite asking for assistance through several avenues, there seems to be widespread lack of support available for those who take the courage to stand up and speak out in order to bring changes to improve staff and health wellbeing. Such courage is for the benefit of being able to provide safe and effective care for those to whom we have a responsibility and duty as dental professionals.

The Royal College of Surgeons of Edinburgh and the CQC have started the #LetsRemoveIt[3] and Freedom to Speak Up[4] national campaigns respectively. The GMC recently announced that they are proud members of the Anti-Bullying Alliance,[5] and are piloting a professional behaviours and patient safety training programme.[6] I am wondering when the GDC and the relevant trade unions representing all members of the dental team will also put their collective efforts into addressing, challenging, changing and preventing such behaviours from persisting, which are sadly still prevalent and inherent within the professions.[7]

A. R. Vora, Sheffield, UK

References

1. O'Dowd A. Regulators to work together on clarifying 'serious' fitness to practise. *Br Dent J* 2019; **226:** 475-476.
2. O'Dowd A. Health service staff stress rising amid plans for mental wellbeing help. *Br Dent J* 2019; **226:** 389.
3. The Royal College of Surgeons of Edinburgh. Anti-Bullying and Undermining Campaign. Available at: https://www.rcsed.ac.uk/professional-support-development-resources/anti-bullying-and-undermining-campaign (accessed August 2019).
4. Care Quality Commission. National Guardian's Office. National Guardian Freedom to Speak Up. Available at: https://www.cqc.org.uk/national-guardians-office/content/national-guardians-office (accessed August 2019).
5. General Medical Council. GMC supports anti-bullying guide for health leaders. Available at: https://www.gmc-uk.org/news/news-archive/gmc-supports-anti-bullying-guide-for-health-leaders (accessed August 2019).
6. General Medical Council. Professional behaviours and patient safety programme. Available at: https://www.gmc-uk.org/about/how-we-work/corporate-strategy-plans-and-impact/supporting-a-profession-under-pressure/improving-support-for-doctors-to-raise-and-act-on-concerns/professional-behaviours-and-patient-safety-programme (accessed August 2019).
7. General Medical Council. An Alliance Against Bullying, Undermining and Harassment in the NHS. Available at: https://www.gmc-uk.org/-/media/about/anti_bullying_alliance_resource_doc_3april2019.pdf?la=en&hash=6B33CB3AB9C87FEE60CA780D1FAB4C5369B5FAAC (accessed 1 August 2019).

https://doi.org/10.1038/s41415-019-0685-9

Orthodontics

Great minds think alike!

Sir, it was with great interest we read the article *An email triage model for personalising paediatric permanent tooth extractions under general anaesthetic* (*BDJ* 2019; **226:** 979-984) by my colleagues in Dorset. Here in Stoke-On-Trent we set up a similar service in 2014 with exactly the same remit. We too would encourage other consultant orthodontic teams to look at email triage particularly for this patient group. This is not just a useful service for scattered rural populations; many of the patients requiring these assessments are from poorer socio-economic backgrounds and have to use public transport and struggle to get from one side of the city to another. They frequently are already poor attenders with a history of failures to attend. Others may have learning difficulties and do not respond well to new environments and strangers directly assessing them. Crucially many patients are in pain and require an urgent opinion to expedite their care and the reassurance from orthodontic team helps both the community practitioners and anxious parents worried about the long term effects of extractions.

To ensure high quality of clinical records and encourage interaction between the teams we undertook some local teaching of the practitioners working in the community service, including basic orthodontic assessment and, crucially, high quality clinical photographs. The latter has meant our requests for face to face assessment are below 10% and the teaching has fostered close working relationships with our community colleagues who know that the team is always available to help.

This model supports the community team in making important extraction decisions which, despite the guidelines, are not always clear cut, and reduces the burden on patients, parents and appointments with busy local consultant orthodontic services.

J. Scholey, J. Shah, K. Juggins, L. Mangnall, R. Ullah, Stoke-On-Trent, UK

https://doi.org/10.1038/s41415-019-0683-y

Water fluoridation

Climate emergency

Sir, the Editor's reminder of the absurdity that is the lack of universal water fluoridation[1] is timely given the current climate emergency. With UK hospitals carrying out approximately 44,000 general anaesthetics a year for tooth decay in children alone,[2] it is noteworthy that some general anaesthetic agents have a global warming potential over 2,000 times that of CO_2[3] with most operating theatres venting these gases straight into the atmosphere. Fluoridation could reduce the need for general anaesthesia for dental caries by 40-50%.[4] Combined with the high carbon footprint of general practice, fluoridation is a means by which the dental profession could make a significant reduction in greenhouse gas emissions.

V. J. Kingsmill, West Sussex, UK

References

1. Hancock S. Koplik's spots. *Br Dent J* 2019; **226:** 909.
2. Child tooth decay figures rise again. *Br Dent J* 2018; **225**: 692.
3. Gadani H, Vyas A. Anesthetic gases and global warming: potentials, prevention and future of anesthesia. *Anesth Essays Res* 2011; **5**: 5-10.
4. Rugg-Gunn A J, Do L. Effectiveness of water fluoridation in caries prevention. *Community Dent Oral Epidemiol* 2012; **40 (Suppl 2):** 55-64.

https://doi.org/10.1038/s41415-019-0682-z

Convincing the public

Sir, I was delighted to learn of the unanimous approval of Local Dental Committees (LDCs) for fluoridation of local water supplies. This is definitely a step in the right direction in the long-drawn-out debate over the safety and acceptability of artificial water fluoridation. However, securing the support of our dentally educated and engaged colleagues is, I feel, a baby step compared to our next challenge: gaining the support of the public.

Working in a tertiary care paediatric dental centre and in a high-needs primary care NHS practice, I sadly witness the devastating effects of early childhood caries on a regular basis. The fact that dental caries remains the most common chronic disease of childhood in the UK[1] is appalling, and warrants a great deal more attention and resources for effective public health initiatives.

The recent Public Health England report stated that the risk of caries experience could be reduced in five-year-olds living in deprived areas by 52% by increasing water fluoride concentration from <0.1 mg/l

to ≥0.7 mg/l. There were no convincing associations found between water fluoridation and hip fracture, kidney stones, Down's syndrome, bladder cancer or osteosarcoma. It concluded that water fluoridation is both safe and effective.[2]

Nonetheless there are still individuals who have been fuelled by misinformation and scare tactics to be staunchly anti-fluoridation. They rely on unreliable media articles and are not practised in critically appraising the poor-quality evidence behind these claims. Therefore, it is our duty to inform and advise them, and in my personal experience even adamant non-believers can be convinced to at least open their minds to the idea.

The ideal solution is mutual understanding: the LDCs should understand their population's uptake of other fluoride products (eg fluoride toothpaste, fluoride varnish) and consumption of tap water,[3] and equally the public need to understand the true benefits of fluoride and its low risk of harm. An evidence-based health promotion campaign would be invaluable to disseminate this information to the masses.

In your recent Upfront article (*BDJ* 2019; 226; **12:** 920) we encouragingly read that 'the network is at the ready to put forward dental and medical spokespeople' to answer questions and provide information; I hope this readiness is being accompanied by an active drive to urge local authorities to hold the public consultations necessary to make a change.

C. Liu, London, UK

References

1. Benjamin R M. Oral health: the silent epidemic. *Public Health Rep* 2010; **125:** 158-159.
2. Public Health England. Water Fluoridation. Health monitoring report for England 2018. London: Public Health England, 2018. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/692756/EXECUTIVE_SUMMARY_Water_Fluoridation_Health_monitoring_report_for_England_2018_DR.pdf (accessed August 2019).
3. Iheozor-Ejiofor Z, Worthington H V, Walsh T *et al*. Water fluoridation for the prevention of dental caries. *Cochrane Database Syst Rev* 2015; **18:** CD010856.

https://doi.org/10.1038/s41415-019-0681-0