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 education

Lack of evaluation tools

Sir, one weakness I have identified with the DFT curriculum is the lack of evaluation tools. Curriculum evaluation plays a vital role in facilitating educational development.[1] Currently, only trainees are required to complete an evaluation, in the form of a national survey. Surprisingly, there does not seem to be a formal method of collating feedback from educational supervisors, who as teachers play a significant role in trainee learning and development. Surely their feedback on aspects of the curriculum such as content, assessment processes and teaching strategies would be of value?

The survey consists of questions concerning an individual's training including supervision and the training environment, as well as more specific questions relating to their programme and assessments. It is fairly detailed and participants are given the opportunity to add comments. Data from the survey are collected and a report is produced, which summarises key findings. However, the last report was published in 2016 and although compulsory, received an overall response rate of 71%.[2]

To improve this aspect of the curriculum, I would incorporate several other methods of evaluation such as conducting informal small group interviews with trainees at the midpoint and end of the training period. The aim of this would be to gain a greater insight into the nature of the curriculum. I would also suggest direct observation of the curriculum in action, such as study days and teaching sessions conducted by the educational supervisor. Through observation, one can learn how not just the planned objectives are taught, but also the unplanned ones! Finally, as alluded to earlier, trainers should also complete a survey at the end of each training period.

Another area to develop would be support for educational supervisors. Due to a busy work schedule, trainers may find it difficult to plan effective lessons, develop their teaching skills, and consolidate existing methods of guidance, coaching and mentoring. I suggest developing a support network where trainers can communicate with each other and appraise each other's lesson plans and teaching strategies. Although it is argued that teacher appraisal schemes aid in motivating teachers to perform better, some trainers may not agree, suggesting that the process could result in loss of confidence, self-esteem or even worse, employment. However, the appraisals process should be seen as an opportunity for professional development and to become better educators of tomorrow's dentists.

H-A. Ismail, West Midlands, UK

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Higher-level dental doctorates?

Sir, I recently attended the primary care academic conference in Leeds. While I was there, I enjoyed several well-considered, comprehensive presentations, but for me, a Magistra Litterarum level practitioner in epistemology, one thing stood out: it seems only higher-level academics understand the nature of knowledge.

My explorations suggest that research funded by the NHS does not support the justified-true-belief theory of knowledge but only truth.[1] This means that only those with higher degrees, who are expected to comprehend the limitations of their methodologies, are able to meet the NHS funding guidelines. I would be interested to know whether the dental community is aware of this shortcoming, and if there is scope for PhDs, lower doctorates, to also gain this understanding, so they can make greater contributions to dental investigation and a stronger, safer, more educated community. In doing so, the NHS and NIHR will enjoy greater value for money.

I wonder if there are members of the dental community with higher doctorate level qualifications, such as the D.Litt, D.D, ScD, MedScD, LLD who may be willing and able to help filter down this learning for the good of dentistry as a whole. Incidentally, my own thesis can only be marked by higher doctorates.[2] I am working to teach the basic principles of the nature of knowledge to my peers, through my LDCs – if you are interested in hearing more about my practice and research or you are a higher doctorate, do please get in touch (Debbie_2383@hotmail.co.uk).

D. Martin, Nottingham, UK

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Regulation

Bullying and harassment

Sir, I am writing to you in response to recent news articles online in the *BDJ* with regards to what is deemed 'serious' with regards to fitness to practise cases conducted by the General Dental Council (GDC),[1] and rising levels of bullying and harassment being reported by NHS staff in the recent 2018 NHS staff survey.[2]

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

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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

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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

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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