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

Elegantly simple

Sir, I am to writing to praise the innovative idea behind 'Dr M's Oral Brush'.¹ What an elegantly simple method of tackling over-aggressive brushing and minimising non-carious tooth tissue loss. I would like to highlight the environmental impact of a product such as this. Not only is this product recyclable but the reusable handle would significantly reduce the quantity of single use plastics (please note that I have no commercial connection or conflict of interest in this product).

Plastics are an enduring pollutant of our oceans and a constant threat for many animal species. I feel strongly about the need for our profession to consider the environmental impact of the single use plastics we use.

O. Marland, Liverpool, UK

References

1. Dentist designs green brush with detachable head. *Br Dent J* 2019; **226**: 995.
<https://doi.org/10.1038/s41415-019-0717-5>

Green dentistry

Single use plastic

Sir, public awareness of the impact that single use plastic is having on the environment has been steadily increasing over the last decade.

Having made attempts in my personal life to reduce my plastic waste I have become increasingly uncomfortable with the amount of single use plastic waste produced for each patient every day in dental practice and hospital alike. As a newly qualified dentist it is unimaginable how much waste I will personally generate throughout my career.

Understandably, cross-infection control plays a major role in this issue, and ultimately major change will lie with the policy makers and manufacturers. However, there are subtle changes that we all could make to significantly reduce

our plastic use. This in turn will reduce the amount of plastic waste being incinerated contributing to pollution and ultimately minimise our impact on the environment. Plastic cups, plastic dappen dishes, disposable aspirator tips, plastic tray liners and plastic protective sheets could all either be swapped for autoclavable or recyclable alternatives or not used at all.

Our patients are increasingly asking for dentist approved environmentally friendly packaged alternatives to toothpaste, toothbrushes and floss. Would these same patients really be upset by a lack of plastic cup to rinse or use of paper towel instead of plastic protective sheet? Somehow, I think not.

R. Timlin, Hartlepool, UK

<https://doi.org/10.1038/s41415-019-0765-x>

Clinical negligence

Inter-professional engagement

Sir, I read the two articles on clinical negligence in the May and June issues^{1,2} with interest. For the last two years I have, together with a lecturer from the Law Department, facilitated a small group of dental and law students at Plymouth University. As adult learners, the two groups of students have together explored a fictitious case, one clearly related to the realities of dental and legal practice, which resulted in a claim of negligence against the dentist.

Within an enquiry-based learning environment, in addition to evaluating inter-professional engagement, the aim of these pilot sessions was to encourage the dental students to ask relevant questions in relation to the case, and with the help of their legal peers, research and gain an understanding of the legal issues which underpin the practice of dentistry. Hopefully the students will be able to transfer the knowledge they have gained to situations that they might encounter in clinical practice in the future.

Sitting early in the undergraduate programme the sessions provided the dental students with an awareness of the law in relation to patient experience and the final year law students gained an insight into the complexities and pitfalls within dentistry. More time would be needed to fully evaluate the impact of the sessions on the two groups of students and, were they to continue, the sessions would need to be fully integrated into the course curriculum.

The module was presented by the project lead, Cathy Coelho, at the Conference of the Association of Dental Education in Europe.

Much is written about the fears which today's practitioners carry regarding legal redress and the impact it has on clinical practice and I hope by developing a greater understanding of the law during undergraduate training this can be put into some sort of perspective.

P. Ward, Plymouth, UK

References

1. Morris C, Chawla G, Francis T. Clinical negligence: duty and breach. *Br Dent J* 2019; **226**: 647-648.
2. Morris C, Francis T, Chawla G. Foreseeability and causation in clinical negligence cases. *Br Dent J* 2019; **226**: 831-832.

<https://doi.org/10.1038/s41415-019-0764-y>

Patient safety

Common sense has prevailed

Sir, I was pleased to read that wrong-site local anaesthetic blocks for dental procedures was removed from the NHS Never Events list in May 2019.¹

'Never events' are defined as 'patient safety incidents that are wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers.' To fit the criteria of a never event, the incident also must have 'the potential to cause serious patient harm or death'.¹

The incidence of permanent nerve damage from inferior alveolar nerve blocks has been reported as being from 1 in 20,000 to 850,000.² While the risk and consequences of this should not be disregarded, it hardly seems comparable to other never events, for example removal of the wrong kidney.

Although the reporting of never events is supposed to encourage learning from mistakes rather than blame, the anecdotal evidence is that they have stigma attached to them and are incredibly stressful for the dentist involved.

It should be noted that the reason given for removal of wrong site dental blocks was that 'systemic barriers are not strong enough to prevent these types of incidents from occurring',¹ rather than the generally reversible nature of the mistake. However, it is still encouraging that dentists' concerns were listened to and that common sense has prevailed.

C. Docherty, Newcastle-upon-Tyne, UK

References

1. NHS Improvement. Never Events policy and framework. 2018. Available at: https://improvement.nhs.uk/documents/2265/Revised_Never_Events_policy_and_framework_FINAL.pdf (accessed July 2019).
2. Pogrel M A. Permanent nerve damage from inferior alveolar nerve blocks--an update to include articaine. *J Calif Dent Assoc* 2007; **35**: 271-273. <https://doi.org/10.1038/s41415-019-0763-zl>

Dental careers

Costs and expenses

Sir, I write to support a recent *BDJ* article entitled *Are researchers paying too much for dental meetings?* (*BDJ* 2019; **226**: 927-929) from a student perspective.

The authors draw attention to the high and ever increasing fees for participants presenting research findings at dental meetings. Scientific meetings present valuable opportunities for networking and research interaction. The importance of research is emphasised in the undergraduate dental curriculum and students are encouraged to attend and share their projects at conferences. Such opportunities can foster motivations towards a career that includes research. However, conference fees present a significant challenge impeding student attendance and participation.

For many students, undergraduate years are a time when finances are stretched. It must be acknowledged that some conferences do offer discounted rates for student attendees, but these often remain costly. Expenses do not end with registration; printing of posters,

subsistence, and travel to conference venues can all add up to surpass the standard student budget. To cover these additional expenses may simply not be possible, especially for students from lower-income backgrounds or who have carer or childcare responsibilities. High fees risk creating an even greater disparity between those students who can and those who cannot afford to attend meetings, yet this is not a criterion to be a good researcher.

Despite frequent inclusion in the 'early career researcher' category for conference registration (and payment), undergraduate students are not eligible to apply for funding from the same grants. While institutional support with costs is an alternative for undergraduates, this is variable and can range from a deficient subsidy to non-existent. Given that funding is limited, staff and researchers who are more established on the career ladder should be prioritised. Student researchers may not bring the same levels of research experience to the table, but costly conference fees and lack of financial support risk excluding students entirely. Are students not encouraged to become the future of these scientific meetings and research conferences? I fear that such costs will rule out, or even deter students from including research in their future careers.

J-Y. S. Yeung, London, UK

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GDC regulation

Erasure

Sir, Dr Bishop (*BDJ* 2019; **227**: 4) draws attention to the reluctance of the GDC to define how serious an offence should be to warrant the removal of a licence to practice. It is accepted that this penalty should be reserved for very serious offences, and the protection of the public.

Despite the bankrupting and professional consequences most dentists would consider this fair. Last year my licence was removed after a patient's mother said I had told her that orthodontic treatment might damage her daughter's face and that I could improve her face. There was no suggestion that I had harmed the patient in any way or that I should refund fees.

Subsequently I sent a copy of my consultation letter to a number of dental colleagues asking if they thought I had been fair. This letter had already been through the County Court and therefore was no longer legally 'confidential'.

The GDC initially suspended me because I had misled the patient and subsequently removed my licence for lack of confidentiality. There were other minor issues which I had strongly contested. What was my offence? Apparently disagreeing with orthodontists from the United Kingdom who claim that it is not possible to change faces for the better or worse.

Internationally there is considerable support for my approach and 32,000 dental professionals have become members of my Facebook site as well as 5,000 'friends'.

J. Mew, Broad Oak, UK

<https://doi.org/10.1038/s41415-019-0761-1>

Dental pain

Painkiller overdoses

Sir, I wish to emphasise the importance of checking for painkiller overdoses whenever a patient presents with dental pain.

An 18-year-old recently attended with toothache. On checking self-medication, over the course of several hours he had taken: 12 x 500 mg paracetamol tablets, 10 x 30/500 mg co-codamol tablets and 4 x 30 mg codeine tablets: ie at least 11 g paracetamol and 420 mg codeine, far above the maximum doses of 4 g and 240 mg. A quick call to the local A+E department confirmed his need to be seen urgently. However, the patient did not share this urgency stating he 'did not fancy a four-hour wait' and would go to his GMP in a few days.

Patients with dental pain frequently accidentally overdose on painkillers with a recent study in the *BDJ* reporting 37% presenting to an A+E department and concluding that this was due to a lack of patient awareness of the potential overdose dangers and inadequate access to dental services.¹ In this case the patient had seen an emergency dentist the previous day who advised painkillers but crucially did not advise on dosages.

The former conclusion is however certainly true. The patient overdosed to help him sleep as 'a few tablets weren't good enough'. As they are easily accessible medications he felt there was no danger in taking more than stated on the box. The effects of an overdose often don't present for several days making patients unaware of the potential harm they have caused. This lack of symptoms was also a deterrent from attending the local hospital when advised.

Teaching on basic pain history includes asking patients if they have taken painkillers and how many. Yet do we all do this? Perhaps