responses from various regions across the UK: 41.7% had already been redeployed into secondary care, with the remainder either waiting to hear about their new placement or had not redeployed. By rating individual factors on a 5-point Likert scale, we were able to determine what influenced their willingness to be redeployed as their decision is a voluntary one.

Perceived lack of provision of adequate PPE, risk of exposure and transmission of COVID-19 to family and friends, and provision of adequate training prior to taking on new roles were ranked highly as deterrents to redeployment. Gaining new skills during redeployment and wanting to work in a larger team ranked highly as positive factors. Interestingly, factors such as working extra or unsociable hours, working in a new location or in a hospital were not ranked as major preventative factors.

In terms of assessing skillsets that DFTs held at the time of redeployment in relation to working in ICU, on average responders had low confidence levels regarding familiarity with ICU lines, phlebotomy, and cannulation. As DCTs we can reassure our junior colleagues that these skills can be learnt with support and will be useful if they are considering further postgraduate training.

These factors provide insight into the driving forces to recruit young clinicians into an unfamiliar role. They may be useful

for key decision makers if we were to have a second peak or another pandemic.

S. Fernando, V. Raniga, M. Cairns, London, UK

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Webinar popularity

Sir, to determine the use and perceived benefit of webinars and online learning, a brief survey was sent to dentists across the UK; 50 responses were received from a mix of those working in general dental practice, hospital and community.

Prior to the outbreak of COVID-19, only 17% of dentists had attended a webinar, however, within the last six weeks 64% have done so. For dentists who have engaged with these, 60% had attended five or more, demonstrating a proactive attitude towards learning; 94% found the content beneficial and 92% stated they would attend a webinar in the future, once social distancing measures have been relaxed.

Interestingly, although there is a clear and obvious advantage of face-to-face teaching, 35% would prefer online over face-to-face. We believe this demonstrates the advantages of online education and a possible shift in the future of teaching. Regarding face-to-face study days, dentists felt the biggest barrier to attending was the ability to get time off work (71%), closely followed by the location, and costs involved with travelling, course fees and hotels. Taking time away from clinical practice has obvious financial implications whereas

webinars offer the flexibility to study during a clinician's own time. Of course, this can only be a supplement and not a replacement for hands-on training. Will COVID-19 change the future of education in dentistry?

J. A. Bell, S. R. Mahmood, Bradford, UK

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DIY ultrasonic scaling

Sir, recently, a friend messaged asking my opinion on a 'DIY ultrasonic tooth cleaner' after deciding that since the dentist is closed she may need to take dental care into her own hands.

I was surprised to discover that commercially available is an 'electric plaque reduction tool'.

These tools were advertised as being designed to effectively reduce dental plaque, dental calculus, hard tartar, stains and help decrease bacteria in the mouth. The design appears similar to that of an electric toothbrush but with a sharp, scaler tip attached rather than a brush head. These devices don't produce water; however, some are advertised as capable of vibrating at a rate of 12,000 times per minute. This tool if used incorrectly has serious potential to cause damage to the periodontal tissues and dentition and I advised my friend accordingly. It is worthwhile readers being aware of these kinds of tools that are available to patients so that the appropriate advice can be given.

S. Pahal, Bristol, UK

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Orthodontics

Safe braces

Sir, the British Orthodontic Society (BOS) and the Oral Health Foundation have recently collaboratively launched a much-awaited campaign, Safe Brace Campaign, alerting the public to the dangers of direct to consumer orthodontics, also known as 'DIY Braces' (www.safebrace.org). Both organisations provide patients with expert and evidence-based information that relates to their oral, orthodontic and overall health.

The campaign was launched after the recent statement released by the General Dental Council recommending that for all dental interventions patients should have a face-to-face consultation with a trained clinician at the beginning of treatment. This is of paramount importance as patients

need to make informed decisions about their treatment, and the only way to do so, is for the patients to see a trained clinician in person to discuss the treatment (and indeed alternatives) in detail (including risks and complications) so that they are fully informed of what to expect from the outset.

Jonathan Sandler, BOS President, said: 'In my professional opinion, if you embark on any orthodontic treatment without a suitably trained clinician taking the time to examine you and make appropriate recommendations, you could be in danger of having serious conditions missed, as well as inappropriate and dangerous treatment carried out. What other transforming dental or medical treatment would you undergo, without an in-person evaluation or supervision by a medical professional?'. He continued: 'For me, one of the issues with "DIY Braces" is

that it offers just one narrow solution when there may be a more appropriate one for the patient. The value of informed choice cannot be over-estimated.' This is a huge step that should, hopefully, raise awareness of the dangers of direct to consumer orthodontics to the general public.

A. Alkadhim, London, UK

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Patient anxiety

A simple pleasure

Sir, I enjoyed the paper entitled *Experience of listening to music on patient anxiety during minor oral surgery procedures: a pilot study* by Gupta and Ahmed¹ and feel that music can be an invaluable tool in calming patients during procedures. Using music as medicine is a safe and non-pharmacological method

of managing anxiety during complex dental procedures and the potential for research in this area is wide. Regarding the study, I pose a question to the authors: I was interested to read that almost half of the participants (48%) reported that music made communication easier and wonder if they could elaborate on this? In my experience, when patients wear headphones and listen to music for distraction and relaxation, communication is negatively affected to some degree in terms of gaining the patient's attention and I wondered how the authors overcame this challenge.

Additionally, it is no secret that dentistry can be a stressful career, now more than ever due to the coronavirus. Stress is believed to be one of the major factors that negatively affect our health, contributing to conditions such as cardiovascular disease, chronic pain and burn out to name but a few.² The calming and stress reducing effects of listening to music have been widely studied and this simple and cost-effective method of relaxation is something easily accessible to all members of the dental team. Well-being is always an important consideration and fundamental to happiness and good mental health. There are so many benefits linked to the simple pleasure of listening to our favourite music and I would encourage my colleagues and peers to think about capitalising on these benefits.

E. Houlston, Bristol, UK

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2. de Witte M, Spruit A, van Hooren S, Moonen X, Stams G-J. Effects of music interventions on stress-related outcomes: a systematic review and two meta-analyses. *Health Psychol Rev* 2020; **14**: 294–324.

The authors Bilal Ahmed and Ashana Gupta respond: we would like to thank Dr Houlston for her question. We too were surprised that 48% of participants found that music made communication easier. We did check the volume with the patient such that there was a balance of listening to the music track and communication with the dental team was clear. Our project involved a surgical motor which is quieter than high speed handpieces.

If we can add there are various genres of music, but our track was instrumental, earth and nature sounds similar to music heard in a spa. There were no spoken words nor an

excessive drum beat or bass. Had our music track been heavy metal or hard rock our result may well have been very different.

Our study only investigated the effect on the patient of music via headphones, not on the dentist. We would agree that dentistry is a stressful profession, but stress is generally hard to measure and includes so many variables outside clinical factors. At our teaching and training centre in Birmingham, we do not play music as this can lead to distraction for our students, trainees and staff. Moreover, playing music in a hospital or clinic does require a licence. As our project suggests patients are welcome to bring their own music using their smart phone and play various tracks using their own headphones.

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Oral surgery

Where do they go?

Sir, as a DCT3 in Oral Surgery I have seen several patients referred for removal of teeth under general anaesthetic (GA) due to dental anxiety. Whilst this is possible for a Tier 3 Oral Surgery service, these patients usually also present with multiple restorable carious teeth which ideally should be restored prior to listing them for the GA, which we unfortunately are not commissioned to provide under this service.

The treatment plan usually ends up advising that their GDP refer them for restorations under IV sedation in a Community Dental Practice (Tier 1) service and be made dentally fit before they get re-referred back to us, solely for the extractions. If this is not possible, the only other option is every single carious tooth will have to be extracted in the same course of treatment under GA, which usually adds up to a significant number for a relatively young adult. This problem is compounded by the common presentation that these patients are usually dental needle phobic, who almost certainly will not tolerate needle plus drilling under single drug IV sedation alone. In some areas they may be able to be referred to a Special Care service, but these are very limited, and the patients may not fulfil the referral criteria. The behavioural decision as to whether these patients 'will not tolerate needle' or 'cannot tolerate needle' becomes so fine that it may be up to the discretion of the clinician on the day. Can they be referred and accepted to undergo cognitive

behavioural therapy? How long is the wait? How many courses of antibiotics can be given for recurrent abscesses before it becomes unacceptable?

The alternative is to accept the patient will undergo repeat GAs and never be encouraged to take responsibility for their dental health. I suspect that as a result of inability or unwillingness of these patients to be treated, and given the options within the existing service, what used to be restorable teeth will be left to cavitate and inevitably become unrestorable, with the same number of teeth or more being extracted in say 12 months' time, compared to if the decision was made to prophylactically extract the teeth with restorable caries at initial consultation, albeit at a different degree of disease progression. As if being bounced backwards and forwards within the health care system is not discouraging enough, in the meantime, who has a responsibility of care for these patients when they are in pain or develop abscesses, and where do they go?

M. Wooi, Liverpool, UK

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Tooth erosion

Food labelling for prevention

Sir, chemical dissolution of tooth hard tissue due to exposure to an acidic environment, namely erosion, leads to tooth surface loss (TSL) with an estimated mean global prevalence of erosion in both primary (30%–50%) and permanent dentition (20%–45%).¹

Extrinsic acids are a major cause of dental erosion and are mainly due to acidic foods and drinks consumed routinely. While most consumers are unaware of the potential harm to their teeth of these items, the same approaches employed to reduce unhealthy food intakes (eg sugar, fat, etc), could also help to reduce TSL.^{2,3} Front of pack food labelling (FOPL) has long been used to help consumers to make informed purchases, although policies are not consistent between different regions and countries. FOPL commonly include types and/or relative amounts of fats, starch, salt, protein and fibre.⁴ It is important for manufacturers to also include acidity of foods and drinks in the labelling. This information should be presented in a manner that is understandable to the general public and not by simply indicating pH value of the products. A traffic