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 ***including*** any references. Authors must sign the letter, which may be edited for reasons of space.

CORONAVIRUS

Pandemic bruxism

Sir, with increasing levels of unemployment, isolation and changes in normal routine during the pandemic, impacts on mental health are unavoidable.[1] Elevated levels of stress and anxiety have a well-established link to bruxism,[2] a common factor that predisposes a tooth to crack and fracture.[3]

Consequently, there has been an increase in patients presenting with features of toothwear, attributed to grinding and jaw clenching. Studies have illustrated increasing levels of bruxism and temporomandibular disorders in those suffering with an aggravated psycho-emotional status.[4] Having diagnosed several patients attending in pain with tooth fractures, the prevalence of such pathology has also been seen increasingly in dental practices.[5]

Conducting a thorough examination, looking for early signs of toothwear and taking a detailed social history can play an important role in establishing a patient's risk of bruxism and tooth fracture. In patients suffering from stress and demonstrating evidence of bruxism, giving advice on how to cope with anxiety, signposting to national agencies and providing interventions such as mouth guards can help to minimise the risk of toothwear and fractures.

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NHS Volunteer Responders Scheme

Sir, the NHS Volunteer Responders Scheme (NHS VRS) was set up as part of the UK government's response to COVID-19 for members of society self-isolating and in need of help. With 2.3 million people identified as clinically extremely vulnerable and another 1.7 million people to be added to the shielding list, the pandemic has left many of our patients feeling isolated, vulnerable and in desperate need of human contact.[1]

According to Age UK, in January 2017, before the pandemic changed our perception of daily life, for people over the age of 60, nearly half a million would usually spend every day alone and another half a million people would go 5–6 days without seeing or speaking to anyone at all.[2] We could be the person our vulnerable patient has sought for help and we can make a difference. The NHS VRS offers services such as delivering shopping, medication and even a 'Check in and Chat' service to regularly call patients, especially those at risk of loneliness.[3] Patients of ours required to self-isolate can even make a self-referral to seek assistance directly.

Therefore, I would like to remind readers that as dental professionals we can refer or signpost our vulnerable patients to the NHS VRS and even volunteer with the Scheme ourselves. Finally, please bear in mind that, sadly, loneliness can kill too just like COVID-19.

S. Patel, Birmingham, UK

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Vaccine hesitancy

Sir, as healthcare professionals (HCPs) from the black community we agree with the letter *Public vaccine distrust* that community level vaccine coverage is crucial.[1]

Vaccine hesitancy was recently noted as highest in Black (71.8%) compared to Pakistani/Bangladeshi (42.3%), mixed ethnicity (32.4%) and non-UK/Irish white (26.4%) ethnic groups[2] with significant differences in the willingness of people from a BAME (Black, Asian and Minority Ethnic) group accepting the vaccine compared to those from white ethnic groups.[3,4] GPs have also raised concerns about low vaccine uptake as a primary care network showed 20–30% of people from the BAME group did not attend vaccines clinics compared to 2–3% in other groups.[5] Worryingly, there is clear evidence that COVID-19 does not affect all ethnic groups equally with disproportionate hospitalisations and excess mortality amongst the BAME community in the first wave, who are, sadly, also reluctant to participate in vaccine trials.[6]

We can relate to the vaccine hesitancy displayed by our community. Historical

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unethical medical experimentation, scientific racism, misinformation and propaganda have fuelled distrust and lack of participation. The Pfizer meningitis vaccine scandal in Northern Nigeria is an example which contributed to the rejection of the polio vaccine years later in 2003.[7,8] HCPs therefore, especially those from these communities, have an important role in myth busting, using an evidence-based approach to dispel misinformation across their networks in a religious and culturally sensitive way.

With the UK set to relax lockdown, we need collaborative, multifaceted approaches to support engagement from the BAME group. The University of Leeds Dental School in collaboration with the National Institute of Health Research released 'Covid and me - vaccines', a short drama series telling stories of lived experiences of vaccine hesitancy of people from the BAME group. With the help of social media, these films have been shared across different Black platforms with the aim of encouraging vaccine uptake amongst these communities.

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Dental radiography

Updated radiograph quality

Sir, in 2001, the National Radiological Protection Board (NRPB) established performance targets for dental radiographs in the publication, *Guidance Notes for Dental Practitioners on the Safe Use of X-ray Equipment*, based on a subjective quality rating system (grade 1 = excellent, grade 2 = diagnostically acceptable, grade 3 = unacceptable).[1] Performance targets for each grade were outlined at 70%, 20% and 10% respectively. Almost 20 years on, and Public Health England has co-published a second edition of the guidance notes with the Faculty of General Dental Practice UK (FGDP [UK]), endorsed by the College of General Dentistry.[2]

One of the key changes includes the new two-point quality rating scale which is recommended for all forms of dental radiography and CBCT imaging. Images are either rated as 'diagnostically acceptable' ('A') or 'not acceptable' ('N'). For digital imaging, no less than 95% should be categorised as 'A', and 5% as 'N'. For film imaging, targets are 90% and 10% respectively. The document describes these targets as representative of what is achievable in the majority of well-managed dental practices. On conducting a review of the literature, this did not identify a single publication where the percentage of grade 3 intra-oral radiographs corresponding to 'N', fell below 5% for digital imaging. This brings to question whether the target is truly achievable.

It can be debated that one of the benefits of separating the previously described grade 2 radiographs from the diagnostically acceptable group, allows for a greater identification of film faults and targeted quality improvement. The GDC principle 7.1.1 states, 'You must find out about current evidence and best practice which affect your work, premises, equipment and business and follow them.'[3] It is important that general dental practitioners and dental care professionals are aware of the updated publication, which is free to access online through the FGDP UK website. If practices struggle to achieve the 5% target, it may be beneficial to undertake audit recording all of the faults from both 'A' and 'N' groups and implement training accordingly.

G. Aruede, Bexley, UK

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Diversity and inclusion

Time for equality

Sir, an independent review into gender pay gaps in medicine found 'the gender pay gap between men and women in medicine is highest for hospital doctors, with female doctors earning 18.9% less an hour when adjusted for contracted hours' and 'women are more likely to work less than full time (LTFT), and most never catch up with male peers even after a return to full-time working'.[1] This will apply to many of our colleagues who work in salaried services, whether it be the community dental service, within hospitals or in academia. I hope the acknowledgement of such data means we can begin to work towards a more equal approach to a career progression in salaried posts.

The report acknowledged 'an unconscious bias amongst peers, recruiters, and even the wider health and care community, that those on LTFT contracts lack the same levels of skill and experience as their full-time colleagues. We must put a value on individual talent and ability, not hours on the clock'.[1] National recruitment into specialty training in 2020 had an emphasis on time, and although I appreciate this was abnormal due to the COVID-19 pandemic, I believe this is going to continue into this year's recruitment. I feel this could cause an inequality for those that have taken time out of training, possibly due to maternity leave, but also health reasons, working abroad,

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