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.

Medical emergencies

Speaker function

Sir, I read with interest the correspondence 'Resuscitation updates' (*BDJ* 2021; **230**: 789). I wish to add that in terms of the changes in the 'Paediatric basic life support guidelines', in addition to what the authors have mentioned, the guidelines have laid emphasis on utilising the speaker function of mobile phones in order to facilitate bystander involvement in the delivery of dispatcher-guided or telephone cardiopulmonary resuscitation and in summoning emergency services without having to leave the infant or child.¹

V. Sahni, New Delhi, India

Reference

1. Resuscitation Council UK. RCUK Guidelines 2021. 5 May 2021. Available at: <https://www.resus.org.uk/about-us/news-and-events/rcuk-guidelines-2021-published> (accessed June 2021).
<https://doi.org/10.1038/s41415-021-3274-7>

Communication

Every word matters

Sir, our choice of words about a treatment has the power to create a perception, be it positive or negative, that will impact the patient's expectation of that treatment. For example, when medical GPs used the words 'heart failure', patients experienced more anxiety and negative expectations of their outcomes than those who heard the positive euphemism 'fluid on the lung as heart is not pumping'.¹

A negative euphemism can have the opposite effect. 'You might need your jaw broken' is both a negative euphemism and largely imprecise. Orthognathic surgery operations have now evolved into sophisticated, largely predictable procedures with fast recovery. The term 'breaking' can be perceived as uncontrolled, random, painful acts and can trigger the fear of surgery in the mouth that already exists in the public psyche. These emotions might lead

to the rejection of the option before a referral occurs and the patient will potentially miss out.

The term 'jaw repositioning surgery' is a better choice. It has the double benefit of describing the treatment more precisely and of not being a euphemism, therefore not losing 'openness' (a frequent trade-off). For patients with subtle dentofacial disproportion but significant dental compensations, jaw repositioning surgery is one of several tools about which to be informed. For patients with more visible dentofacial disproportion, surgery is the only tool to fix the jaw position. We should be careful not to discourage the opportunity to explore this.

Therefore, the language used matters. Replacing 'jaw breaking' with 'jaw repositioning' helps to guide the patient to explore all their options without a fear-based rejection before a referral. This also cultivates a deeper trust with the clinician who took the time to reassure and guide. In the words of Noam Chomsky: 'Language etches the grooves through which your thoughts must flow'.

N. Adali, London, UK

Reference

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<https://doi.org/10.1038/s41415-021-3279-2>

Cosmetic dentistry

Return of the ohaguro

Sir, we would like to highlight an ancient practice of teeth blackening that has resurfaced in the rural areas of Cambodia, Thailand and Vietnam. This trend was born from an antiquated way of preventing tooth decay. In ancient Japan, women painted a solution called kanemizu onto their teeth to protect the enamel and give the appearance of blackened teeth. The solution was made out of ferric acetate from iron filings mixed with vinegar

and tannin from vegetables or tea. This custom was called ohaguro.¹ These blackened teeth were deemed alluring and beautiful, and the practice continued through the centuries to demonstrate sexual maturity in women over the age of 18. It is said to have strengthened the teeth and protected a person from dental problems such as cavities and gum disease.

Ohaguro was banned by the Meiji government in 1870 and the art of dyeing one's teeth was almost forgotten.¹ However, today, ohaguro is practised by many across Southeast Asian and Oceanic cultures, particularly among Austronesian, Austroasiatic and Kra-Dai-speaking peoples. Although the process is harmless to the teeth, it has an unpleasant appearance to it.² Being used to white teeth as the standard, many visitors are shocked to see women with black teeth walking around. They assume that such people have poor oral hygiene, mistaking the dye for caries, while others, having realised that the blackening was done on purpose, wonder why people would 'disfigure' themselves in this way.

A. Venugopal, Chennai, India; A. Marya, Phnom Penh, Cambodia

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1. Live Japan. Ohaguro: The Beauty of Blackened Teeth in Old Japan. 14 February 2017. Available at: <https://livejapan.com/en/article-a0001026/> (accessed May 2021).
2. Zumbroich T. 'We Blacken Our Teeth with Oko to Make Them Firm': Teeth blackening in Oceania. *Anthropologica* 2015; **57**: 539–555.
<https://doi.org/10.1038/s41415-021-3280-9>

Orthodontics

A position of balance

Sir, in 1949, I was taught that the teeth were in a position of balance between the tongue, the cheeks, the lips and the occluding teeth. I believe every dental student since then has been taught the same. Therefore, I was surprised to see little reference to this in your articles about orthodontic relapse in the recent

themed issue of the *BDJ*. In 1981, I suggested that correct posture should ensure straight teeth for life.¹ Oral myologists are trained to do this. Appliances can also change posture, then no retention is required, but I don't think this is taught in any British university?

J. Mew, Kent, UK

Reference

1. Mew J R C. The aetiology of malocclusion: can the tropic premise assist our understanding? *Br Dent J* 1981; **151**: 296–302.

<https://doi.org/10.1038/s41415-021-3281-8>

Microbiology

Cannabinoids – high expectations?

Sir, health stores have been rolling up sales following a relatively recent addition of CBD products onto their shelves due to their implication in several health benefits. This raises the question: are there any potential dental uses for cannabinoids in the pipeline?

In the last few years, CBD has been incorporated into multiple products ranging from face creams and teabags to pure CBD oil taken sublingually for its muscle relaxant and anxiolytic effects. It has also been found to be antimicrobial against gram-negative and gram-positive bacteria.¹

These findings have potential implications within dentistry, as there is little research currently available on the efficacy of cannabinoid molecules in targeting oral commensal bacteria found in dental plaque. Incorporation of cannabinoids into dentifrices may have positive outcomes on prevention of periodontal disease. Studies conducted recently had small sample sizes and lacked reproducibility; thus, more research is needed in this area.

The current legal status of healthcare products containing cannabinoids stands that any cannabis-derived product with more than 0.01% THC (psychoactive component of cannabis) has to be prescribed by a specialist doctor. Over-the-counter cannabinoid products may be sold without a 'hemp licence,' if the THC component is not detected (0.01% as verified by accredited ISO lab).

As outlined in a paper published in the *BDJ* in 2016,² smoking cannabis with tobacco can have detrimental effects in the oral cavity. Namely, lasting xerostomia post-oral cannabis use, cariogenic foods consumed after use, higher DMFT scores in cannabis users compared to non-cannabis smokers, risk of thermal injuries to soft tissues, higher risk of

oral candidiasis and potentially a greater risk of oral cancer compared to non-cannabis smokers. More research is needed on the impact of non-smoking-related oral use of cannabinoids, such as in toothpaste or mouthwash.

Larger studies should be conducted to ascertain whether there are beneficial outcomes for patients with high plaque levels. Research thus far has shown similar bacteriocidal efficacy to the gold standard chlorhexidine digluconate without the detrimental staining potential.³ However, the authors of the study were found to have conflicts of interests as they are financially invested in cannabinoid production. It would be interesting to explore the dental potential of cannabinoids in future unbiased studies.

S. Antoniou, London, UK

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2. Joshi S, Ashley M. Cannabis: A joint problem for patients and the dental profession. *Br Dent J* 2016; **220**: 597–601.
3. Stahl V, Vasudevan K. Comparison of efficacy of cannabinoids versus commercial oral care products in reducing bacterial content from dental plaque: a preliminary observation. *Cureus* 2020; doi: 10.7759/cureus.6809.

<https://doi.org/10.1038/s41415-021-3282-7>

The practice of dentistry Standards in dentistry

Sir, we read with great interest the letter from E. Roberts-Harry entitled 'Guidelines are not standards'.¹ The letter covered succinctly and eloquently the many challenges the dental team face in the UK and the point made about 'The GDP is stuck between a rock and a hard place' rang true, when considering the many pressures as highlighted.

In writing the second edition of the FGDP(UK) *Standards in dentistry*,² and the third edition of *Clinical examination and record keeping*,³ the editors were acutely aware of, and hoped to address, a number of the issues raised by E. Roberts-Harry. For example, in *Standards in dentistry*, we highlighted the definitions as follows:

'Clinical guidelines are systematically developed statements to assist practitioner and patient decisions about appropriate healthcare for specific clinical circumstances.

'A standard is a definable measure against which existing structures, processes or outcomes can be compared'.

Similarly, the editors highlighted the following:

'Any measure of performance has to:

'Be judged against minimum standards, not aspirational standards, that were acceptable at the time.

'Be considered within the specific context of the particular patient and environment.

'Take account of the practitioner's justification, which should be evident from the records'.

The FGDP(UK) has worked tirelessly in preparing such documents, and as we move forwards through the College of General Dentistry, these will be at the heart of establishing evidence-based guidelines and standards for the whole dental team.

E. McColl, R. Witton, C. Tredwin, A. Pal, I. Mills, Plymouth, UK

References

1. Roberts-Harry E. Guidelines are not standards. *Br Dent J* 2021; **230**: 688.
2. Moles D, Tredwin C, McColl E, Robert W, Burns L. *Standards in dentistry*. London: Faculty of General Dental Practice (UK), 2018.
3. Hadden A M. *Clinical examination and record keeping*. London: Faculty of General Dental Practice (UK), 2016.

<https://doi.org/10.1038/s41415-021-3283-6>

Law and ethics

Breakingbury v Croad: should we have seen this coming?

Sir, the recent case of *Breakingbury v Croad*¹ triggered shock waves among practice owners.² Many of us empathised with the retired Mr Croad when he was found liable for negligent work carried out at his dental practice by self-employed dental associates. However, since the principles which led to the findings of a non-delegable duty of care and vicarious liability by the County Court have been made clear by the Supreme Court for almost a decade, should we have seen this coming?

In *Woodland v Essex County Council*,³ the Supreme Court emphasised that there are five defining features whose presence give rise to non-delegable duties of care. With words pertinent to dental services highlighted herein in brackets, these are: that the claimant is a patient; there is an antecedent relationship between the claimant (the patient) and the defendant (the practice owner) which places the claimant in the actual care of the defendant and from which it is possible to impute to the defendant the assumption of a positive duty to protect the claimant from harm; the claimant has no control over how the defendant chooses to perform those obligations; the defendant has