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.

Communication

Words matter vitally

Sir, I read with interest the letter 'Every word matters' by Dr Adali regarding how language affects patients' interpretation of what clinicians say and influences their treatment choices.¹

I agree that language is extremely important. This applies to clinicians as words, and particularly diagnostic terms, affect dentists' decision-making about treatment. We asked dentists to choose their preferred treatment for cases after we supplied the diagnosis and radiographs.² When 'chronic' was used instead of 'asymptomatic' (eg chronic apical periodontitis versus asymptomatic apical periodontitis), there were highly significant differences for all conditions regarding whether the dentists would treat the tooth or not. When 'acute' was used instead of 'symptomatic', there were significant differences for most conditions. This indicated that dentists were more likely to base treatment decisions on the presence/absence of symptoms rather than on the disease itself which is a serious concern. Hence, terms used for diagnosis are important as they influence dentists' decision-making. Similar findings were reported in the medical literature, where practitioners were more likely to treat 'chronic malaria' than 'asymptomatic malaria'.³ These studies demonstrate 'words do matter'.

There are many other words that have crept into the 'common vocabulary' of dentists, yet they are inappropriate. Two examples are 'leakage' and 'vitality tests'.

'Leakage' presumably means something is getting into the tooth but the public are likely to think something is escaping from the tooth. Hence, 'restoration breakdown' and 'bacterial penetration' – which describe the process occurring – are more appropriate.

'Vitality test' implies assessment of the pulp's blood supply, but thermal and electric pulp tests can only assess the ability of the pulp to respond to a stimulus (ie 'sensitivity'). The term 'vitality' leads to use of 'vital' and 'non-vital' for the diagnosis – but both are completely inadequate to indicate the various stages of the pulp/root canal disease process with a blood supply and stages without a blood supply.^{4,5} Use of inappropriate terms should be avoided. They also suggest a poor understanding of what is happening in the tooth.

Dentists should consult their dictionaries from time to time because words do matter!

P. V. Abbott, Perth, Western Australia

References

1. Adali N. Every word matters. *Br Dent J* 2021; **231**: 69.
2. Bestall S, Flynn R, Charleson G, Abbott P V. Assessment of Australian dentists' treatment planning decisions based on diagnosis. *J Endod* 2020; **46**: 483–489.
3. Chen I, Clarke S E, Gosling R *et al*. 'Asymptomatic' malaria: a chronic and debilitating infection that should be treated. *PLoS Med* 2016; doi: 10.1371/journal.pmed.1001942.
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5. Abbott P V, Yu C. A clinical classification of the status of the pulp and the root canal system. *Aust Dent J* 2007; **52**(1 Suppl): S17–S31.

<https://doi.org/10.1038/s41415-021-3474-1>

Dental education

£10,000 swap?

Sir, I read with much interest a piece in *The Guardian* describing the state of affairs with respect to the new intake of undergraduate dental students.¹

A-level 'grade inflation' has reached a record high, with a significant rise in applications to study dentistry at universities throughout England. Although the government has temporarily adjusted the cap on places available to study dentistry for those who have achieved the required

grades (a move welcomed by the Dental Schools Council), it is difficult to envisage where these places will come from. Dental schools' capacities are limited and the resources required to train each student are considerable. The number of chairs and simulators available is difficult to scale up, a problem exacerbated by the limitations imposed by COVID-19 restrictions.

The option to defer or move to different dental schools has been mentioned, with some institutions offering £10,000 compensation if applicants move from one oversubscribed institution to another! I am concerned that this may prove detrimental to future prospective students.

I empathise with applicants – applying for dental school is a stressful process and the added pressures of 'musical places' no doubt intensifies the situation. It seems the effects of the ongoing pandemic will be felt in the education sector for many years to come, although I do not doubt the ability of institutions to adapt accordingly.

M. Adam, Preston, UK

Reference

1. Fazackerley A. Dental students in England offered £10,000 to switch university. *The Guardian* (London) 2021 August 15.

<https://doi.org/10.1038/s41415-021-3481-2>

Paediatric dentistry

Note it down for next time

Sir, when treating children, the use of supportive communication has the power to facilitate effective behaviour management and enable the provision of successful treatment.

We would like to share a little snippet of clinic practice which we have found works well with paediatric patients from first contact to between dental visits, either review to review or treatment session

to treatment session – each visit, simply make an additional note in your clinical records about personal details ‘for next time’ (FNT) – school accomplishments, extracurricular activities, favourite flavour of ice cream, upcoming events etc all serve as excellent examples. Many children are delighted to share their interests and hobbies, and keeping a record of these helps the team initiate the conversation at future appointments, demonstrating a caring attitude towards the child and helping them to relax before commencing the planned activity. It would be impossible to physically remember personal details about each and every child you see; therefore, we suggest clinicians implement the use of an FNT section in their clinical record keeping and watch the delight and improved interaction of each child when you mention what they told you last visit.

C. Donnell, L. Jepson, Sheffield, UK
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Greater BLS emphasis

Sir, further to the correspondence entitled ‘Paediatric BLS’ by S. H. Thakkar (*BDJ* 2021; 231: 145), the author points out the relatively greater emphasis placed upon adult Basic Life Support (BLS) over its paediatric version. The ‘Paediatric BLS guidelines’ (2021) have laid out paediatric modifications to the adult sequence of CPR.¹ These are aimed to be taught to individuals involved in paediatric care but who are unlikely to face a situation wherein they might have to resuscitate children. The average dentist would seem to fit this description. In general, it is stated that rescuers lacking knowledge in the specifics of paediatric resuscitation should follow the adult sequence.¹

Certain paediatric modifications to adult CPR have been mentioned:¹

1. Institution of five rescue breaths prior to initiating chest compression
2. In the case of a lone rescuer, CPR should be performed for one minute before help is sought
3. Chest compression should be for at least a third of its depth, which is around 5 cm for older children and 4 cm for infants
4. For infants, two fingers or both thumbs, and for a child older than one year, one or both hands must be used to attain adequacy of depth in chest compressions

5. A compression rate of 100–120 per minute should be maintained.

V. Sahni, New Delhi, India

Reference

1. Resuscitation Council UK. Paediatric basic life support guidelines. 2021. Available at: <https://www.resus.org.uk/library/2021-resuscitation-guidelines/paediatric-basic-life-support-guidelines> (accessed August 2021).
<https://doi.org/10.1038/s41415-021-3483-0>

Professional development

The webinar storm

Sir, we read with interest the letter ‘Real dentistry amidst the reels’ (*BDJ* 2021; 231: 206–207). A key aspect of social media, as mentioned in the letter, involves professional networking of doctors. This interaction involves digital information sharing, continuing professional development (CPD) programmes, case discussions and analysis, which bring dentists from different parts of the world under one umbrella, for the single purpose of providing better patient care.

We would like to highlight the countless webinars in the past year alone that have provided dentists with a huge platform to share knowledge with others sitting on the other side of the world, mostly free of cost. In addition, many social media online ‘groups’, especially on Facebook, have been instrumental in disseminating information and knowledge in the past year.

However, there is an issue here. Amongst the genuine scientific webinars, conferences and ‘posts’, there lie many ‘brand-driven’, sponsored ones with hidden agendas, promoting products amongst a plethora of social media ‘professional’ groups. In other words, confirmation bias, where there is a tendency to only consider information that supports one’s existing beliefs or theories, seems to run unabated. The absence of a qualified scientific committee in many such social media professional groups and conferences may result in inappropriate screening, leading to inexperienced speakers, inadequate quality of attendees and, more importantly, paltry scientific power of lectures.

A usual presenter in such brand-driven conferences appears to have a profile of a clinician talking to their audiences about his or her success in selected cases with untested, filtered experience confined to his or her private practice alone. In other cases,

information is broadcast on a personal website or webpages, portraying the owner’s opinion, only to be believed by a majority of gullible public as ‘hard science’. However, we live in times where testimonials, case reports, lectures by ‘clinical experts’ given by paid experts, all supplemented with proprietary publications, are seemingly enough for many concepts to be tacitly acceptable. We hope this attitude changes, for the better of our beloved profession.

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Dental history

Thanks is due

Sir, through the letters pages of the *BDJ*, we would like to thank the library and museum of the BDA who through their collections and curatorship maintain the history of the dental profession.

We were inspired to place our appreciation on record since the British Society of Paediatric Dentistry (BSPD) and its official publication, the *International Journal of Paediatric Dentistry* (*IJPD*), are celebrating two anniversaries this month: 30 years since the inaugural issue of the *IJPD* and 50 years since the first issue of the *Proceedings of the British Paedodontic Society* (*PBPS*). The British Paedodontic Society (BPS) was a forerunner of BSPD and the *PBPS* was our first ever publication.

We were able to enjoy reading and sharing an electronic copy of the first *PBPS* thanks to BDA librarian Helen Nield, who located the issue in the BDA library (Fig. 1). The BDA museum and library provide a wonderful service to all those who care about dentistry.

Fig. 1 The cover of the first issue of the *Proceedings of the British Paedodontic Society*

S. J. McKaig, BSPD President, UK
<https://doi.org/10.1038/s41415-021-3485-y>