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.

Water fluoridation

Kids don't drink water

Sir, following your reprint from the archives questioning the necessity of six-monthly check-ups[1] – especially in 'fluoridated' areas – my hygienist pointed out a further issue in that, as she said, 'kids just don't drink water any more…'

I'm sure this might be a very relevant factor. Energy drinks and bottled water seem to be the drinks of choice. Maybe the BDA could lobby drinks manufacturers to fluoridate their products?

D. Burton, Leatherhead, UK

References

1. Sheiham A. Is the six-monthly dental examination generally necessary? *Br Dent J* 2022; **233:** 774–775.

https://doi.org/10.1038/s41415-022-5358-4

Head and neck cancer

Additional resources

Sir, I enjoyed reading the articles on the management and rehabilitation of head and neck cancer patients in the 11 November issue of the *BDJ* (Volume 233 Issue 9). I would like however to comment on Drs Kalsi, McCaul and Rodriguez's article on the role of primary care practitioners in the dental after-care of such patients.[1]

A number of practical challenges exist to delivery of continuing care in general dental practice. Firstly, treatment in the General Dental Service in the United Kingdom incurs charges (for those not in exempt groups). This may be a barrier to some in seeking care.

The transition from hospital treatment to primary dental care, for which there is a charge, questions the principle of the NHS to provide appropriate healthcare free at the point of delivery. Is this routine dental treatment or the ongoing management of the consequences of the malignancy?

Second, complex rehabilitation with free flaps and/or implant anchorage, poor oral access, unusual tissue morphology and unconventional restorations may be markedly different from that with which general dental practitioners are familiar and may pose real challenges in primary care. Have they received any practical training or support in managing such patients? As recurrent disease and technical complications may well occur and require early (often specialist) intervention, a properly trained and funded continuing care network is essential. As there appears to be an increase in head and neck malignancy, I think these issues need addressing by those commissioning and providing such care.

R. Saravanamuttu, London, UK

References

1. Kalsi H, McCaul L K, Rodriguez J M. The role of primary dental care practitioners in the long-term management of patients treated for head and neck cancer. *Br Dent J* 2022; **233:** 765–768.

https://doi.org/10.1038/s41415-022-5362-8

Oral health education

Loss of situational control

Sir, we read, with interest, the article '"It's their mouth at the end of the day": dental professionals' reactions to oral health education outcomes'.[1] It highlights an important issue and verifies the results of our research exploring dental stressors, where some dentists volunteered that they became frustrated or irritated (anger group emotions) by 'patients' [failure to] take responsibility for their own oral health: "after [you keep] giving them oral hygiene advice … and they just don't really care"' (pp 405).[2]

Such frustration may be driven by underlying anxiety about future claims of supervised neglect as well as a genuine desire to do the best for the patient. Dentists may experience a perceived loss of situational control, particularly if the patient wants treatment that is inappropriate to their current oral hygiene state.

Assuming you can or should change other people's behaviour is a cognitive error[3] or thinking trap,[4] as we highlighted in the training package that was evaluated as part of our research.[5] As stated in that training, 'you can never make other people change their behaviour – it is their right and responsibility to do so... You have a professional responsibility to diagnose, treat, inform and transfer skills. It is up to the individual to choose to apply that knowledge and to put those skills into place' (unpublished manuscript, reference available from the authors).

Respect for autonomy is central to shared decision-making, a process facilitating integration of patient preferences with the evidence- and experience-based advice and recommendations of the practitioner, thus allowing mutually agreeable treatment decisions.[6] These decisions may appear unwise to the practitioner but should be respected.

As Barnes and colleagues discovered, appropriate coping strategies for this situation are acceptance and reappraisal[1] which, again, confirms our findings.[5] These coping skills are associated with reduced vulnerability to burnout, depression, anxiety and stress.

H. R. Chapman, N. Golijani-Moghaddam, Lincoln, UK

References

1. Barnes E, Bullock A, Chestnutt I G. 'It's their mouth at the end of the day': dental professionals' reactions to oral health education outcomes. *Br Dent J* 2022; doi: 10.1038/s41415-022-4978-z.
2. Chapman H R, Chipchase S Y, Bretherton R. Understanding emotionally relevant situations in primary care dental practice: 1. Clinical situations and emotional responses. *Br Dent J* 2015; **219:** 401–409.
3. O'Doherty K M. *The little book of thinking errors.* London: Cognitive Therapy Books, 2009.