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

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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

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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.
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Oral diseases

WHO report

Sir, the WHO has recently published a 'Global Oral Health Status Report' which is a first of its kind document detailing the burden of oral disease the world over.[1]

It observed that nearly half (45%) of the world's population is affected by oral diseases which amounts to 3.5 billion people. Three out of four of these people are located in countries belonging to the middle- and low-income groups. Over the past 30 years, there has been an increase in oral disease cases to the tune of one billion. The WHO notes that this increase may be attributed to people having inadequate access to the treatment and prevention of oral diseases.

The report highlights that dental caries, severe disease of the gums, oral cancers and tooth loss are the most common diseases of the mouth. Amongst these, with 2.5 billion people affected, untreated caries is the most common, with a further 1 billion people being affected by severe forms of gum disease which is a major cause of total loss of teeth. Further, the report mentions that approximately 380,000 fresh oral cancer cases are diagnosed yearly. Oral diseases are seemingly rampant in disadvantaged and vulnerable groups wherein those with disabilities, low incomes, older individuals living in care homes or alone, minorities as well as people living in rural and remote areas being representative of increased burden of disease.

This pattern is along similar lines to other non-communicable diseases such as CVS diseases, cancer, mental disorders and diabetes. This apparent 'crisis' shares risk factors common to other non-communicable diseases as well, such as tobacco and alcohol use along with high sugar consumption. In this report, the WHO identifies barriers to oral health care delivery such as the requirement of high expenditure, specialised and expensive delivery models out of touch with primary healthcare delivery systems as well as poor surveillance and information systems placing low priority on public-level research.

Some opportunities for improvement have been identified, such as adopting strategies to target common risk factors, integrating oral health care at the national level and in universal coverage systems, integration of oral heath-related information into national monitoring systems as well as restructuring healthcare delivery models and competencies of non-dental health care professionals.

V. Sahni, New Delhi, India

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