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.

CHEESE CLARIFICATION

Sir, in relation to information reported in the *BDJ*, I wish to clarify the position of the British Dental Health Foundation.

As organisers of National Smile Month we take oral health promotion very seriously and were disappointed to discover the British Cheese Board (BCB) had distributed a press release before the campaign containing misleading information and without our authorisation.

The release suggested we were working with the BCB to 'encourage children to chew a small portion of hard cheese after consuming a sugary drink or snack.'

We are very clear in our advice to the public to limit the consumption of sugary food and drinks and are disappointed that the BCB issued the release after we had asked for it to be withheld.

N. Carter
Chief Executive, BDHF
DOI: 10.1038/sj.bdj.2009.417

CHILD ANXIETY

Sir, anxiety or fear affects a child's behaviour and to a large extent, determines the success of a dental appointment. Anxiety is generalised apprehension due to the unknown or a new situation whereas fear is a state of apprehension based upon actual experience, memory and imagination. Dental fears are acquired – not innate. Several factors affect children's behaviour in the dental office: parental anxiety – particularly maternal – being an important one. Most investigators indicate a significant relationship between the level of maternal anxiety and the behaviour of their children in the dental office. It has been seen that high maternal anxiety tends to affect children's behaviour negatively. The effect of maternal anxiety is greatest with those under four years of age, though children of all ages can be affected. This might be anticipated because of mother-child symbiosis that begins in infancy and gradually diminishes with age. Early mother-child interaction is critical in determining the child's later socialisation and ability to adapt to situations requiring adjustment. Children below the age of four years behave better with their parent present; however, parental presence or absence did not seem to significantly affect the behaviour of children older than four. However, separation anxiety when the parent is removed is a normal developmental stage, and young children are best treated with a parent present.

Since maternal anxiety is closely associated with children's behaviour, strategies that aim to decrease parental anxiety may also improve children's behaviour. The dentist must help the parent to understand that what will happen allows them to prepare their child and improves the treatment alliance by reducing the child's anxiety. Preparatory information sent prior to first appointments produced improved behaviour compared to children whose parents had not received information. In circumstances of high maternal and child anxiety, efforts should first be made towards instituting behaviour management skills like 'tell show do' and modelling to bring about a higher level of cooperation before starting a treatment. By passing special attention to these children, it is possible that the dentist would succeed in improving the acceptance of treatment, thus making children's first and subsequent dental visits enjoyable for child, parents and dentist.

R. K. Singh, A. Kumar, S. Singh, Lucknow
DOI: 10.1038/sj.bdj.2009.418

SET UP TO FAIL

Sir, it has been noted by many education providers that some of the trainee dental nurses they are expected to get through the training are considered to be 'high maintenance'. By some, it may be considered the GDC's responsibility to regulate the basic line of education each trainee should have before being taken on a course, since they claim to 'assure the quality of dental education'.

Perhaps the National Examining Board for Dental Nurses should have a say since they insist that any provision for the National Certificate is accredited and standardised? When approached the NEBDN did indeed say that it is 'up to the individual education provider to decide on the entry requirements'. Education providers then have to take a stand, but since it is not they who actually 'take on' the trainees, they simply have the issue of the theoretical training of them. A difficult situation is then afoot when a trainee approaches a course provider and on the application form states they have been working in practice for a few months and really want to do this course; they have managed to gain GCSEs at 'D' and 'E' grades and wish to be a great asset to the practice.

Education providers have been concerned, since we live in such a litigious society, that perhaps they [the education providers] could be formally sued by a trainee because they cannot get through the training! Badly sourced dental nurses are for all intents and purposes being set up to fail! My opinion it may be, but I believe this issue needs to be bounced back to the source of the problem: the employers. It is time to look at the bigger picture and see that potential trainee dental nurses need to be 'savvy' enough to get through

training or you are simply wasting your time, energy and more importantly your money. If the interview and selection process is better laid out and the employers realised the benefits of better organisation during these important steps, the problems facing the training providers and ultimately the employers would be considerably reduced. The employers also need to take a more serious look at the part they play in the training of the trainees. It is no longer acceptable to 'pay off' the education provider and then expect to get your trainee back qualified. It is so important that employers and providers work together to offer a more jointly run and cohesive course, so that the standards of training and ultimately patient care does not suffer.

Forgive me for seemingly generalising, but for many years many dentists have taken on employees with little thought about their long-term prospects and what that employee will offer their practice. In some cases, the employer has taken on the school leavers with minimal qualifications just so they can pay them less than the minimum wage, they cannot expect training providers to work miracles and get them through a training course which is beyond their capabilities.

Interviews are an integral part of the recruitment process. The one-to-one contact can provide an in-depth impression of how a candidate would perform on the job. Getting the most out of interviewing is a combination of preparation, suitable questioning and listening.

If the applicant gained 'D' and 'E' grades in their GCSEs ask them why? If they fooled around in school, ask yourself, will they be reliable and will they be a great student during training?

If future employers take this seriously, then the education providers will have a more enjoyable journey along with any potential dental nurses for the future. Come on please, look at the bigger picture.

L. C. Hampshire, By email

DOI: 10.1038/sj.bdj.2009.419

IGNORING THE ISSUE

Sir, my letter to you *Beyond the pale* (*BDJ* 2009; **206:** 188) was written in a personal capacity for good reason and not by somebody representing any commercial interest.

It is unfortunate that the emotive response from Messrs R. J. Crisp and F. J. T. Burke ignores the central issue of the paucity of science-based dental standards upon which dental professionals can assess the value of the products they buy. This is particularly ironic in the light of a recent article written by Professor Burke[1] who reviewed 102 papers published on the subject of bond strengths and complains 'there is little standardisation of test methods and a number of potentially significant variables may not be reported or recorded'. Exactly my point Professor – a similar review of 102 CAD/CAM methods used in the manufacturing of ceramic artefacts may well come to the same conclusion owing to a complete lack of any relevant standards. General practitioners and patients have suffered too long from materials and products that fail and are not fit for purpose.

If Messrs Crisp and Burke are serious then they should prepare themselves for the issue of their P45 as I am aware of a software tool that will examine dental restorations and it is a necessary part of the R&D I carry out as a self employed dental consultant. It can be used as an audit tool to monitor the quality of clinical preparations and ensures that the digitising process conforms to the requirements of BS EN ISO 10360 Pt IV. In addition the dental manufacturing processes with which I am associated are all BS EN ISO 13485 compliant.

N. J. Knott, By email

1. Burke F J T, Hussain A, Nolan L, Fleming G J. Methods used in dentine bonding tests: an analysis of 102 investigations on bond strength. *Eur J Prosthodont Restor Dent* 2008; **16:** 158-165.

DOI: 10.1038/sj.bdj.2009.420

RENEW EFFORTS

Sir, I was interested to read the recent letter (*BDJ* 2009; **206:** 187) by my former Merseyside colleague John Doughty. I agree with him that the arguments in favour of water fluoridation have weakened since 1974-75 when he was Area Dental Officer for Sefton AHA. Indeed, as early as 1987-88 my colleagues and I in the North West published two papers in the *BDJ* making just that point.[1,2] The BDA has argued for years in favour of a targeted approach to water fluoridation to around 30% of the UK population.

Colleagues from Southampton have highlighted the particular problems in deciduous teeth because:

- DMFT values have been resistant to change (see South Central Strategic Health Authority's consultation paper at http://www.southcentral.nhs.uk/document_store/1220390484zWbv_water_fluoridation_consultation.pdf
- Severe deciduous caries impacts on the quality of life of young children[3]
- The resulting need for dental general anaesthetics in Southampton (more than 500 cases per year):
  - are expensive for the NHS
  - have short term psychological effects on the young children involved[4]
  - have long term effects in causing dental anxiety among adults.

Professor John Newton, Regional Director of Public Health, South Central Strategic Health Authority has once again emphasised the safety of water fluoridation and I congratulate the SHA on their recent decision in favour of new water fluoridation schemes for Southampton (http://www.southcentral.nhs.uk/news.php?news_id=177).

I shared John Doughty's frustration at our failure to implement water fluoridation in the 1970s, but urge him to renew his efforts in the North West of England. It is just possible that this time someone might listen to him.

M. A. Lennon OBE

Chair, British Fluoridation Society

1. Duxbury J T, Lennon M A, Mitropoulos C M, Worthington H V. Differences in caries levels in 5-year-old children in Newcastle and North Manchester in 1985. *Br Dent J* 1987; **162:** 457-458.
2. Mitropoulos C M, Lennon M A, Langford J W, Robinson D J. Differences in dental caries experience in 14-year-old children in fluoridated south Birmingham and in Bolton in 1987. *Br Dent J* 1988; **164:** 349-350.
3. Sheiham A. Dental caries affects body weight, growth and quality of life in pre-school children. *Br Dent J* 2006; **201:** 625-626.
4. Bridgman C M, Ashby D, Holloway P J. An investigation of the effects on children of tooth extraction under general anaesthesia in general dental practice. *Br Dent J* 1999; **186:** 245-247.

DOI: 10.1038/sj.bdj.2009.421

HIV RULES

Sir, the DOH guidance entitled 'HIV Infected Health Care Workers' says that HIV infected health care workers should avoid exposure prone procedures which for a dentist effectively means restricting practice to full dentures and teaching. I know of several dentists who became HIV

positive and had to give up practice but having read an article in the 21/2/09 edition of the *New Scientist* I wonder if the time has come to change the guidance. The author (Clare Wilson the medical features editor) explains how the progress of HIV is gauged by measuring the level of CD4 cells - immune cells the virus infects and kills. In the past treatment with antiretroviral drugs only commenced when the CD4 level fell below 200 (it is 500 or more in a healthy person) but now people who once had to take 20 tablets a day are down to one or two a day with fewer side effects and it appears there are health benefits from taking the drugs at an earlier stage when the CD4 level is higher.

The article states that people who are scrupulous in taking their tablets may have no virus detectable in their blood and that 'doctors now see patients with normal CD4 counts asking to start therapy purely to avoid passing on the virus.'

So, if an HIV positive dentist adopted an appropriate regime of antiretroviral drugs such that s/he no longer had any detectable virus in their blood would this mean they could not infect patients and therefore be able to treat them? If so then is it time to change the rules?

T. Lynn, Andover

DOI: 10.1038/sj.bdj.2009.422

ANOTHER HICCUP?

Sir, the requirement for a consultant oral and maxillofacial (OMF) surgeon to be concurrently registered with the GDC and the GMC ceased in April 2008.[1] Our specialty is now recognised as a medical specialty and removing the long-standing requirement for dual registration was seen as the only logical mechanism acceptable to the GDC to prevent OMF surgeons being required to revalidate twice.[2] This has, however, given rise to an unfortunate anomaly with regards to the employment of temporary registered dentists within our departments. The temporary registered dentist must have his/her temporary registration with the GDC countersigned by the supervising consultant, who in turn must be currently registered with the GDC.[3]

It has therefore become incumbent upon the supervising consultant to re-register with the GDC in order to employ the temporary registered dentist. This requires not just the registration fee of £438.00 but also a restoration fee of £110.00. The NHS as the employer has declared that they are not responsible for this payment.

The OMF consultant therefore, yet again, has to pay for dual registration and the GDC would appear to be receiving two registration payments and a restoration fee for the temporary registration of one person. The consultant surgeon would also be expected to comply and keep evidence of the CPD requirements of the GDC. I believe the financial penalty and CPD requirements burdened upon the consultant to be wholly unreasonable. I also believe that the necessity for a consultant to potentially pay £548.00 may well be enough incentive to give rise to actual or perceived bias during an open and equal opportunity interview. The employment issues alone necessitate an urgent re-evaluation of this situation. Unfortunately the GDC has declared no intention of reviewing this policy and I believe the British Association of Oral and Maxillofacial Surgeons needs to approach the GDC at the earliest opportunity to resolve this matter.

S. Laverick, Dundee

1. British Association of Oral and Maxillofacial Surgeons. President's newsletter. April 2008.
2. Martin I. Oral and maxillofacial surgery – future uncertain? *Ann R Coll Surg Eng (Suppl)* 2009; **91:** 95.
3. General Dental Council. Report of the registration review group. Nov 2002; 10.16-10.17.

DOI: 10.1038/sj.bdj.2009.423

DEPLORABLE CARE

Sir, with reference to Dr Korada's letter *Care for all* (*BDJ* 2009; **206:** 396) I regret to confirm that in my own experience in London, Plymouth and Torbay the oral care of residents in care homes is deplorable. Sadly, meeting colleagues from around the UK and abroad this appears to be an international problem.

The British Society of Gerodontology is committed to improving these patients' care and I would like to invite Dr Korada and any other colleagues interested in this sphere of practice to take the opportunity to meet at the BSG's scientific meeting 'Looking after the Nursing Home Patient' in Newcastle on 26 June 2009. Details may be obtained from contact@gerodontology.com.

R. Baker, Newton Abbot

DOI: 10.1038/sj.bdj.2009.424