Letters to the Editor

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LETTERS

INVERSE CARE LAW

Sir, we agree with Davies and Bridgman (*Br Dent J* 2011; 210: 59-61) regarding methods of improving oral health among children. Indeed, we once trusted in the virtuous circle of prevention: *education, knowledge, awareness, long-term effectiveness*. We must now acknowledge that education alone cannot guarantee an effective prevention and may increase health inequalities; but there is something worse. Knowledge is a necessary but not sufficient condition for awareness, which is the perception and the cognitive reaction to an event, and parents' knowledge does not necessarily imply their awareness. For example, despite expensive and nationwide campaigns specifically directed to adults from low socio-economic strata in the USA and Australia, many parents do not seat their children in the rear seats of passenger vehicles, smoke at home and are not aware of their children's nutrition. The unpleasant aspect of these examples lies in the dichotomy between parents' knowledge and awareness toward their children's health.

This paradoxical effect, called the Inverse Care Law ('individuals and groups who are in minor need of an intervention benefit more from it than those who are in major need'), was enunciated by Julian Hart in 1971,¹ is now corroborated by many examples, and applies also at community level, since public water fluoridation in Brazil is more common in wealthy than in poor municipalities.² *Co-morbidity* and *fatalism* amongst low-income strata are the major factors associated with the Inverse Care Law. Underprivileged individuals and families frequently

suffer many conditions simultaneously, which compromise health and social problems; the most common of them is psychological distress. Early childhood caries is associated with psychological distress³ and parents with such co-morbidity do not necessarily concentrate their attention on caries.⁴ Fatalism is the view that we are powerless to do anything other than what we actually do. Fatalistic individuals believe that there is nothing they can do to cure or prevent any condition that they are fated to develop, regardless of their level of health literacy. Among low-income communities, such as the Chinese and the African-American communities in the UK and USA, fatalism is associated with poor oral health. Fatalism and co-morbidity may act synergistically, leading to aboulia and the unlikelihood to adopt any health (including oral health)-oriented behaviour.

How can we get rid of the Inverse Care Law? The approach proposed by the Viennese psychiatrist Arthur Adler was that only healthy individuals, with a complete state of physical, mental and social wellbeing, may change and improve their lifestyle. Therefore, the prerequisites for health of the Ottawa Charter for Health Promotion (such as income, stable eco-system, education, sustainable resources, social justice) evoked by Davies and Bridgman are the fundamentals to achieve the goal of oral health for all without inequalities.

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DOI: 10.1038/sj.bdj.2011.291

TRAUMA TRAINING

Sir, we wish to highlight the findings of an audit of the location and time to initial presentation following periodontal ligament injuries in permanent teeth carried out in the Paediatric Dental Department of Glasgow Dental Hospital & School.

Data were collected retrospectively, regarding the place of initial presentation and time until presentation following dento-alveolar injuries, from the dental records of patients who were subsequently referred and treated in the department. Data were collected for 162 patients aged 6-15 years and revealed that following a dento-alveolar injury, 54.4% of patients initially presented to Accident and Emergency Departments of General Hospitals (A&E), 28.5% to general dental practice, 8.9% to the Dental Hospital and School (GDHS), and 8.2% to the Community Dental Service (Primary Care and Salaried Dental Service). Only some 39.8% of patients presented within the first hour following the injury.

The prognosis of traumatised teeth depends on prompt and appropriate emergency management. Data regarding the standard of initial trauma management provided at primary care treatment facilities were beyond the scope of this audit. However, unfortunately Abu-Dawoud¹ reported that very few physicians would provide appropriate emergency treatment and suggested

that all medical staff personnel should receive simple instructions about management of dental trauma. Both Lin *et al.*² and Levin *et al.*³ also stated the importance of providing primary caregivers with the relevant education to improve their knowledge and ability of dealing with diagnosis and treatment of dental trauma. However, it is not only medical primary care providers who need continuing education and training in dental trauma. Hu *et al.*⁴ reported that general dental practitioners may also have limited knowledge in dental trauma management.

In conclusion, this audit revealed the majority of dento-alveolar trauma is likely to initially present outwith the dental hospital trauma clinic and highlights the need to ensure the provision of training in the management of dental trauma encompasses all centres likely to be presented with these injuries. Regular and repeat training to include rotational medical junior staff will be required and protocols for treatment and pathways of advice and referral should be clear and practical.

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I. Shafi,
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DOI: 10.1038/sj.bdj.2011.292

NEEDLE RE-SHEATHING

Sir, we have recently received information from the local infection control specialist on the new EU directive banning re-sheathing of needles, which came into effect last year.

We run a large organisation where the dentists are split between using fully disposable syringes and metal syringes with disposable needles and resheath-

ing devices such as the Jenger. The directive is specifically called 'COUNCIL DIRECTIVE 2010/32/EU of 10 May 2010 implementing the Framework Agreement on prevention from sharp injuries in the hospital and health-care sector concluded by HOSPEEM and EPSU' which states, 'the practice of recapping shall be banned with immediate effect'.

I would like to pass on this information as it is as yet not to the best of my knowledge a well known directive within the profession (not surprising with the huge amount of bureaucracy we have suffered under as a profession as of late). Also perhaps the topic can be debated openly and advice for all members obtained as I know many of our own dentists will not be happy moving to fully disposable systems in favour of their favourite metal syringes.

R. Emanuel
Haywards Heath

DOI: 10.1038/sj.bdj.2011.293

ODONTOIATROS

Sir, I write further to K. Wilson's letter explaining the translation of the German word for 'dentist' (*BDJ* 2011; **210**: 53).

The same applies to Modern Greek, where the word for dentist is 'odontoiatros'. *Odonto* means of the teeth, and *iatros* is doctor. So a Greek dentist is also a tooth doctor.

D. Cooper
Halesowen

DOI: 10.1038/sj.bdj.2011.294

AN INTEGRAL LINK

Sir, at a dental conference held on 9-10 November 2009 in Göteborg, Sweden, at the initiative of the dental company Oral Care AB, a network of experts in geriatric dentistry was founded.

This interdisciplinary and autonomous network of expertise in areas such as pharmacology, pharmacokinetics, basic research, medicine and dentistry, will formulate guidelines for future geriatric dentistry. The group will work on quality assurance, quality development, as well as basic and applied research.

One of the objectives of this work is to promote dentistry as a natural and integral part of the chain of care of elderly and medically debilitated

people, in which dentistry is highly neglected today. Studies have shown that one in ten deaths from health care-related pneumonia in the elderly could be prevented by improving oral hygiene.

The number of elderly is growing rapidly in Europe and worldwide, but resources to provide good dental care are lacking to a large extent. This will inevitably lead to great suffering for this often multi-disease patient group, with malnutrition and worsened general health as the consequence. At the first meeting, the network therefore discussed how dentistry should be designed to rapidly meet this growing dental care need. It was also concluded that it is one thing to provide treatment of oral diseases, but equally important is to address the prevention of them.

At the 46th annual Swedish Dental Congress on 19 November 2010 in Göteborg, Sweden, Oral Care held an interdisciplinary symposium on elderly and geriatric dentistry, and provided informed on how IT support may be used in outreach geriatric dentistry.

About Oral Care AB

Oral Care is working with mobile dental care, where the main benefit for the patients is that both preventive measures and treatments can be given where the patient lives: at nursing homes or in private residences. Oral Care's complete preventive dentistry system also contributes to community benefits by decreasing the burden on the health care organisations by reducing the risk of morbidity. Oral Care conducts research in collaboration with leading academic institutions to develop tomorrow's geriatric dental care, with a strong focus on the links to medical benefits for the individual that adequate dental care among the elderly will lead to.

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U. Fagerholm,
Å. Rundgren,
P. Sjögren
Sweden

DOI: 10.1038/sj.bdj.2011.295

REFORMING SURROUNDINGS

Sir, over the last few decades, the patient-clinician relationship has changed drastically. Today, the principle of patient