from different specialities were asked to contribute. The leaflet was then taken to the Assistant Chief Dental Officer for Scotland, Mary McCann, who put me in touch with a dental public health consultant, Colwyn Jones, who has been instrumental in making the project a success through his contacts and previous experiences.

Further ideas were contributed by a second multidisciplinary group, this time involving specialist addiction pharmacists, and an NHS design team who ensured that the leaflet met NHS rules and regulations relating to the leaflet design.

It has taken three years, but finally, the number of leaflets chosen to be produced by NHS Scotland was 25,000. The cost of printing these was £627 (or 3p per leaflet). Dentists can now work alongside pharmacists in order to make a small but important contribution in reducing drug-related problems in Scotland.

G. Isherwood
Edinburgh

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DIGITAL NATIVES

Sir, I attended the opening of the British Dental Conference and Exhibition in Manchester this year when Susan Greenfield OBE gave an excellent session. She spoke for an hour without notes, PowerPoint or any other visual aids but engaged the majority of her audience in such a spellbinding way that it was a surprise when she finished.

During her talk she referred to the 'digital native'. This describes a person who was born during or after the general introduction of digital technology and who has interacted with digital technology from an early age. She quoted research that some young people are spending 30 hours a week interacting with their screens. She suggested that this group of people have an under-developed hippocampus and referred to some evidence for this. One effect upon such a person is a lack of empathy. In my opinion empathy must rank alongside clinical skill and the ability to communicate, as one of the essential qualities needed by dentists.

During this talk I was surrounded by a group of young members of our profession who spent the entire talk turning the pages of their programmes loudly, texting or whispering to each other. What better evidence of the lack of empathy possessed by the 'digital native'?

After the session I spoke to a group of foundation dentists who had, like me, been thoroughly engaged by Baroness Greenfield and for whom the morning had been a genuine pleasure.

Perhaps the future isn't all bad!

M. Green

By email

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LONG-TERM APPEARANCE

Sir, I read the paper by McDowall, Yar and Waring (*BDJ* 2012; 212: 417–423) with some concern. Most orthodontists would accept that dental and facial objectives occasionally conflict¹ and many now avoid closing anterior spaces for fear of 'dishing in the face'. Unfortunately the very regulations that are intended to protect patients may prevent them from making the most important decision about their treatment: 'will it improve my long-term appearance?' Valid consent is only possible if patients can be shown facial photographs of alternative approaches; see www.orthotropics.com.

The authors also recommend moving the lateral incisor mesially without tilting. If this is attempted after the apex has closed noticeable root resorption will take place² especially in laterals.³ They also recommend intrusion but this may increase root resorption even more.

Root resorption often followed by mobility is routine following fixed appliances^{4,5} but due to a lamentable lack of research we are quite unable to forecast the long-term consequences.

J. Mew

By email

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FAILED SMILE DESIGN

Sir, we would like to take this opportunity to add to the debate highlighted in *Ethical issues in cosmetic dentistry* by M. Kelleher (*BDJ* 2012; 212: 365–367) and show how failure of this type of cosmetic dental treatment can impact on a patient's life.

Our community dental service treats patients with moderate to severe special care needs. It is uncommon that we come across patients who demand 'ideal smile designs', as our patients generally have pressing complex social, medical and psychological problems to deal with. We were therefore surprised when this 26-year-old female, who is homeless with other complex problems, presented to us as an emergency patient seeking help with her veneers, which she complained 'would not stay on' (Figs 1–2). Further examination revealed 12 veneers extending from UL6 to UR6 of which five had failed. On questioning, the patient revealed that they were fitted less than a year ago, under sedation, and when the veneers

Figs 1–2 A 26-year-old patient with failed veneers and multiple deep carious lesions