

Letters to the Editor

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A WARNING FROM THE PAST

Sir, in 1965 I supported Jack Alexander, Hans Eirew and Bill Frankland in forming the British Association of Orthodontists which was open to all orthodontists and dentists with an interest in the subject, and mainly through their efforts it quickly became the largest UK orthodontic body. Over the years many specialist orthodontists joined the association and in 1971 full membership became restricted to those with a specialist diploma or degree, the remaining dental members being excluded from voting. In 1994 the Association combined with four smaller organisations to become the British Orthodontic Society. At that time the largest group within the membership were general dentists but they were denied voting powers. In 1998 the General Dental Council created specialist registration and initially no general dentists were allowed to claim any expertise in orthodontics even if they had been practising it exclusively for many years.

The increasing use of systems such as Invisalign and the current popularity of 'six month smiles' has inspired a new generation of dentists who wish to know about alternative techniques. I mention this because they have founded a new organisation, the European Society of Aesthetic Orthodontics, quite independently of any of the current orthodontic groups. What has amazed me is that now, as in 1965, there has been a huge demand for membership of this new group. Their inaugural meeting, on 14 December, was oversubscribed to such an extent that it had to find larger premises on three occasions and that was two months before it took place. This could signal the demand for wider debate and

I am sure that many readers of the *BDJ* would like to be involved. Past history has much to warn us about the future.

J. Mew, by email

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SYMPTOM PRESCRIPTION

Sir, sucking of the thumb, digits or dummies is common childhood behaviour, which has an adaptive value for children up to the fourth year of life. A chronic prolonged habit may cause deleterious effects on dentofacial structures. A wide range of methods have been used for helping children quit their habit. They are generally categorised as operant procedures and sensory attention procedures. The operant procedures include contingency reinforcement and reframing. The sensory attenuation methods tend to interrupt the sensory feedback experience with the sucking habits either by appliance therapy or response prevention.

We would like to share our experience of using a concept of psychotherapy called reverse psychology, or symptom prescription, in treating children with a thumb sucking habit.

Symptom prescription is a technique whereby you address the symptoms that someone brings to therapy by encouraging them in some way to engage in those symptoms.¹ It helps in solving the problem by prescribing the very behaviour which has been viewed as the problematic one.² It is generally believed that appliance therapy might not be really effective unless the child really wants to quit the habit, as they can always create newer ways to continue the habit. Dunlop beta hypothesis, a technique used in treatment of thumb sucking, is probably based on this concept. Each child is

made to sit in front of a mirror and asked to suck his thumb, observing himself as he indulges in the habit. If he can be forced to concentrate on the performance of the act at the time he practises it, he can learn to stop performing the act. Children were asked to repeat the same in their home for an hour every day for one week and to report for re-assessment. Forced purposeful repetition of a habit eventually associates it with unpleasant reactions and the habit is abandoned. We believe that children aged five and above, with adequate cognition, could be helped to quit their bad habits and reinforce good oral habits, if this technique can be used the right way.

Sharath Asokan, Geetha Priya PR
Tiruchengode

1. Wiki Answers. What is symptom prescription in family therapy? Available at: http://wiki.answers.com/Q/What_is_symptom_prescription_in_family_therapy (accessed 19 November 2013).
2. O'Connell D S. Symptom prescription in psychotherapy. *Psychotherapy: Theory, Research, Practice, Training* 1983; 20: 12-20.

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TREATMENT CONSENT

Sir, I am writing in reply to the case reported by Stagnell and Burrows¹ regarding a 69-year-old lady who had an unusual cementoma removed in their department. In their letter, the authors state, '*Given her lack of capacity to consent, she was consented for by her daughters and the senior members of the team*'. The current law in England and Wales is that no-one may consent to treatment on the behalf of a non-competent adult; instead it is their best interests that govern whether treatment is carried out.² Whilst I am sure that the authors acted in the best interests of the patient, it is a mistake to state that

consent was gained from her family or team members. Unless the patient has executed a lasting power of attorney (LPA) whereby a patient nominates a chosen donee (or donees) to make decisions on his or her behalf then nobody but that patient may consent to medical treatment. The authors make no reference to an LPA existing. When consent cannot be gained, it is for the clinicians involved to act in that patient's best interests; acting in a non-competent patient's best interests is not a tautology for gaining consent. This might be seen by many to be focusing too much on minutiae, but as the law is heavily dependent upon the words, terms and phrases used, it becomes increasingly important to ensure these are correct.

A. C. L. Holden

1. Stagnell S, Burrows G. Cojoined cementoma. *Br Dent J* 2013; **215**: 267.
2. Mental Capacity Act 2005 s.1(5)

Drs Stagnell and Burrows respond: We wish to acknowledge the response to our original publication: we would like to make clear, that all guidelines are followed routinely whilst engaging in clinical activity with particular reference to the Mental Capacity Act and matters of consent. In this case, the patient's daughters did carry LPA, and we appreciate it was an oversight to have not made reference to this in our initial article and we apologise for any confusion or concern caused.

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IT'S BEEN SAID, STUPID

Sir, on reading your timely editorial, *It's the environment, stupid*,¹ I paused on your comment that 'environmental issues in dentistry, and indeed medicine, have received scant attention...'. I did this as lead author of a paper entitled *Dental practice and the environment*,² published in 1998. This paper, which summarises the issues considered to be pertinent to the environmental effects of the clinical practice of dentistry in the 1990s, stemmed from a lecture I presented at the Silver Jubilee Meeting of the British

Society for Restorative Dentistry, held in 1993. The lecture was entitled *Are dentists an environmental hazard?* To the best of my knowledge, Professors Mjør and Bellinger (an environmental scientist) and I were on our own at the time in publishing on the subject of dental practice and the environment.

The world has moved on since the publication of that paper but I would suggest that much of its content remains relevant today. Materials and agents used in the clinical practice of dentistry which may pose a hazard to the environment include anaesthetic gases (also gases used in conscious sedation), base metal debris, disinfectants, etchants, monomers (ie initiators, accelerators, inhibitors, stabilisers, primers and conditioners) and associated reagents, clinical waste, X-ray processing solutions and drugs, including antibiotics. With the growing popularity of procedures such as tooth bleaching, which relies on the action of one or more reducing agents, and the increasing use of 'bioactive' materials in dentistry, the list of dentally related hazards to the environment, in my opinion, is no longer complete. As such, much-needed, would be 'champions of green thinking' in dentistry need to think much more widely than indicated in your editorial. Critically, in environmental auditing, it is important to adopt a 'cradle to grave' approach as, only by considering the sourcing of raw materials and the manufacturing, use and eventual disposal of consumables, devices and equipment is it possible to define the 'environmental footprint' of an activity. Such thinking is clearly behind the Minamata Convention which requires dentistry to phase down the use of dental amalgam.

As discussed in my earlier paper² we must not expect individual countries or regions to realise environmental goals and responsibilities by imposing costly additions to existing regulation. The environmental impact of dentistry may be relatively small but this does not exonerate anyone from critically reviewing and reducing the environmental

impact of their clinical practice. As with recycling, switching off unnecessary lighting, turning down the heating thermostat and not running water while brushing your teeth, if everyone in the profession did something, the overall effect would be substantial. Needless to say, the safety of patients must never be compromised in making the practice of dentistry more environmentally friendly. As in all matters in clinical practice, the interests of the patient come first.

N. Wilson, by email

1. Hancocks S A. It's the environment, stupid. *Br Dent J* 2013; **215**: 375.
2. Wilson N H F, Bellinger E G, Mjør I A. Dental practice and the environment. *Int Dent J* 1998; **48**: 161-166.

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EXUBERANT HYPERCEMENTOSIS

Sir, Stagnell and Burrows report a case of 'cojoined [*sic*] cementoma' affecting the maxillary central and lateral incisors (*BDJ* 2013; **215**: 267). The racial origin of the patient, presence or absence of Paget's disease of bone and the vitality status of the affected teeth are not specified. 'Cementoma' is not recognised by the World Health Organisation in its latest classification of odontogenic tumours¹ and the maxillary incisors are very unusual sites for any of the cementogenic entities it currently lists. The case in point is likely to represent exuberant hypercementosis associated with non-vital, functionless teeth, ie a reactive rather than neoplastic process which was the result of long-term periapical inflammation. However, the history of oral bisphosphonate therapy is intriguing. One might speculate on its role in producing the pathological changes which, in turn, caused the surgical difficulties described and it is unfortunate histological data were also not included.

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1. Barnes L, Eveson J W, Reichart P, Sidransky D (eds). *World Health Organization classification of tumors: pathology and genetics of head and neck tumors*. Lyon: IARC Press, 2005.

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