students with life skills, which they can carry into their professional career. Dental schools should, if they are not already doing so, adopt the following measures to reduce the incidence of burnout amongst their students:

1. Have realistic expectations of students in designing and revising the undergraduate curriculum to meet university and regulatory requirements
2. Educate students and staff on the risk factors, signs and symptoms of burnout
3. In the regular monitoring of students, pay special attention to assessing and identifying any signs and symptoms of burnout
4. Provide opportunity, and encourage students to develop a work-life balance, which enables them to maintain their endurance, energy and commitment.

Susceptibility to burnout may be measured using simple questionnaires: the 22-question MBI (healthcare specific format) or the 30-question ProQOL. Both require low student compliance being readily administered at, for example, the end of a lecture or clinical session. Keeping records of scores may help identify the possible onset of depersonalisation in individuals and the need to take action, possibly helping a student avoid burnout. Such scores may be used also by students for self-reflection on their work-life balance and the management of their studies. The major advantage is the empowering of the student to self-diagnose and manage any symptoms of burnout.

D. S. Aulak, B. Quinn, N. Wilson, by email

1. Denton D A, Newton J T, Bower E J. Occupational burnout and work engagement: a national survey of dentists in the United Kingdom. *Br Dent J* 2008; **205**: 377–384.
2. Billingsley M. More than 80% of medical students with mental health issues feel under-supported, says Student BMJ survey. *Studentbmj* 1 September 2015. Available at: <http://student.bmj.com/student/view-article.html?id=sbmj.h4521> (accessed February 2016).

3. Singh P, Aulak D S, Mangat S, Aulak M. The significant factors contributing to burnout in dentistry. *Occup Med (Lond)* 2016; **66**: 27–31.

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ORTHODONTICS

Fast removal of claims

Sir, I think it worthwhile to bring to your readers' attention the result of an investigation by the Advertising Standards Agency (ASA) that was sparked, in part, by a previous discussion in these letters pages on the potential merits of Fastbraces.^{1,2}

The ASA are a body funded by a levy on UK advertisers who take action against misleading, harmful or offensive advertisements. The ASA cannot investigate complaints on international websites. The main promotional Fastbraces website is not based in the UK.

I highlighted concerns I had about claims on a UK website relating to Fastbraces' efficacy and comparisons to other brace treatment (faster treatment, less painful treatment, less root resorption during treatment etc). I felt that these claims were unsubstantiated and misleading to potential patients. The ASA agreed to investigate whether 'the efficacy claims made for Fastbraces were misleading and could be substantiated'.

In a recent letter the ASA informed me that the website had agreed to remove such claims and that 'they will not appear again in the absence of adequate evidence'. As such, the issue was 'informally resolved'.

Given recent research into orthodontic practice websites published in this Journal that demonstrated generally poor compliance with GDC guidelines on ethical advertising,³ this development serves to highlight the risks to colleagues (and patients) and challenges that can occur when manufacturers' claims are presented

via a practitioner's own website.

Whilst I have no issues with the use of Fastbraces or any branded orthodontic appliances, if claims are advertised that a dentist (specialist or not) cannot legitimately back up, then it may not only be the ASA that takes umbrage, but also the GDC.

N. Stanford, by email

1. Huntley P. Orthodontics: Fast and furious. *Br Dent J* 2015; **218**: 2–3.
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3. Parekh J, Gill D A. The quality of orthodontic practice websites. *Br Dent J* 2014; **216**: E21.

DOI: 10.1038/sj.bdj.2016.157

DENTAL TRAUMA

Splinting with wire and composite

Sir, as clinicians at King's College Hospital and Board members of Dental Trauma UK we read the recent paper on avulsed permanent teeth with great interest and were a little surprised by the comments made subsequently by letter.^{1,2}

In the letter the authors mention a number of aspects of the management of dental trauma and in particular the use of orthodontic brackets for splinting traumatised teeth.² Unfortunately, their notion that orthodontic brackets may be better than composite and wire splints for repositioning avulsed teeth is definitely not our experience, nor is it evidence based.

The letter asserts that the use of orthodontic brackets is the 'first choice' for both adult and paediatric patients in secondary care. We would disagree strongly with this, especially when considering the guidance in the dental trauma guide that the authors cited. In our opinion, orthodontic brackets are tricky to use especially by non-orthodontic specialists and most primary care practitioners are unlikely to have them readily at hand. Their