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.
2. Kilcoyne A. Orthodontics: Fast and furious. *Br Dent J* 2015; **218:** 265–266.
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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

suggestion that composite is 'tricky' to place in these situations is an odd one bearing in mind that most practitioners would find bonding to the buccal surfaces of anterior teeth, isolated with cotton wool and gauze, relatively straightforward.

Dental Trauma UK have published a video on quick and easy splinting using wire and composite which can be viewed at https://vimeo.com/137957560.

It is our opinion that primary care dentists have the necessary skills to effectively bond composite to tooth tissue. What they may lack is the experience and skills to diagnose and manage acute dental trauma. This was evident in the Kenny *et al.* study which revealed a need for appropriate postgraduate training in managing dental trauma in children; unfortunately this is likely to translate to an equal or possibly greater need in the adult patient.[3] With this in mind we feel that a sensible way forward would be to introduce management of dental trauma as a core subject similar to medical emergencies. In this way dentists could be updated annually thereby going some way to improve their knowledge, skills and confidence.

Dental Trauma UK (www.dentaltrauma.co.uk) is a charity aiming to improve the management of dental trauma by raising awareness in the general public on what to do if a tooth is avulsed as well as educating dentists in the management of all of the other types of dental trauma.

S. Djemal, A. Alani, by email

1. Gilchrist F. Primary care dentists' experience of treating avulsed permanent teeth. *Br Dent J* 2015; **219:** 216–217.
2. Allison J R, Garlington G. Orthodontics: Treating avulsed permanent teeth. *Br Dent J* 2015; **219:** 514–515.
3. Kenny K P, Day P F, Douglas G V, Chadwick B L. Primary care dentists' experience of treating avulsed permanent teeth. *Br Dent J* 2015; **219:** E4.

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WORKFORCE PLANNING

The specialist map

Sir, in 2014, I was working on a presentation and produced a prototype specialist map which was included in the British Society of Paediatric Dentistry's submission[1] to the Commons Health Committee inquiry into Children's Oral Health.[2] Graphs and tables are useful but maps give a unique perspective.

Using publicly available data from the GDC specialist's register and a modified postal area map, a 'UK Specialists in Paediatric Dentistry Map' was possible. A more recent version is shown in Figure 1.

Part-time and full-time specialists cannot be determined and some locations are not the place of work. The percentage of administration and face-to-face clinical time cannot be determined nor can the proportion of private and NHS care. Population data are not superimposed. This prototype is rather crude but it is a start.

If the GDC modified their database slightly as well as requiring the main work address, both the profession and government may better estimate what specialists are doing and where in the NHS.

If all specialities were mapped and placed in specialist layers on a single map, different specialty distributions may be observed by digitally adding and subtracting layers. Mapping by the GDC of clinicians registered with them has significant potential and we could see dental therapist maps for example too. Mapping products may be of commercial interest giving the GDC another income stream.

R. W. Mills, Devizes

1. Written evidence submitted by the British Society of Paediatric Dentistry (COH0014). 18 February 2015. Available at: http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/health-committee/childrens-oral-health/written/18127.html (accessed March 2016).
2. House of Commons Health Committee. Oral evidence: Children's oral health, HC 1912. Tuesday 24 February 2015. Available at: http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/health-committee/childrens-oral-health/oral/18366.pdf (accessed March 2016).

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GDC Paediatric Specialist register	n = 234
UK	n = 227
England	n = 171
Scotland	n = 29
Wales	n = 13
Northern Ireland	n = 14

NB - postal areas can straddle national borders

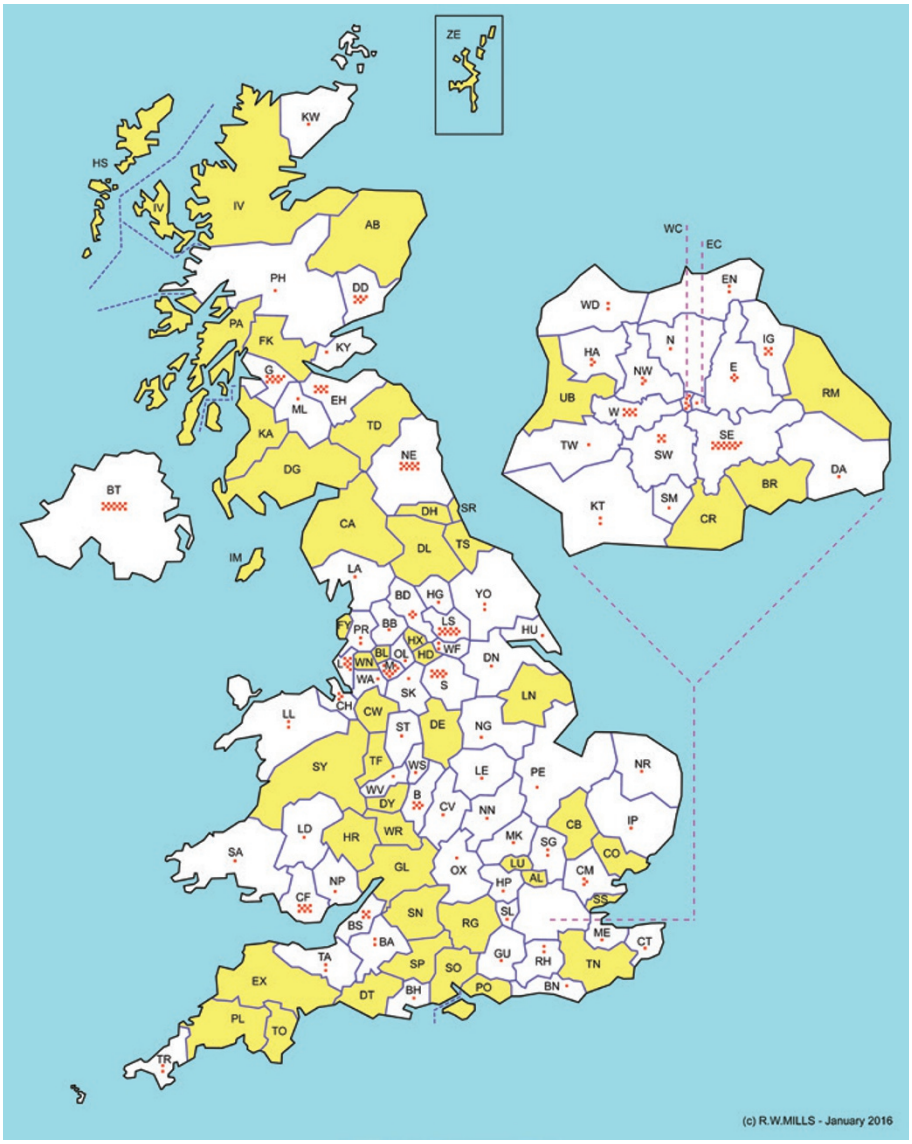

Fig. 1 Specialist Paediatric Dentists in the UK in January 2016 according to postal region where registered. Squares represent each specialist and shaded areas have no GDC entry