COMMENT

Letters to the editor

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Oral health

Flossing has to be taught well

Sir, in spite of recent US health official's pronouncements and those of the scientific advisers of the BDA that flossing is ineffective, I would offer a word of caution before 'banning' patients from flossing their teeth. I am a retired specialist periodontologist and a past Director of the Army School of Dental Hygiene, Aldershot.

When teaching hygienist students I felt it incumbent upon myself to 'practise what I preached'. I started to floss my teeth daily and have done so religiously every day since over the last 46 years. I have no gingivitis, no periodontal diseases and have not required any restorative work for the same period of time.

Flossing has to be taught well. It is not an easy task to master but it does work when patients are taught how to floss effectively on a daily basis. I accept there are other equally effective and perhaps easier to use interdental tooth cleaning aids now available, ie interdental brushes etc, but floss will still continue to have its uses in places where mini brushes cannot go and is performed correctly on a daily basis.

J. Hardy, Farnham

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Orthodontics

Irresponsible articles

Sir, looking through the dental press over the last few months I have come across some irresponsible articles on quick forms of orthodontics – irresponsible claims and treatment by the authors and irresponsible editors for publishing them. Free speech is one thing but we do live in a world of evidence-based dentistry, never mind integrity.

In the letter section of the *BDJ* Volume 220 issue 9 (13 May 2016) Nicky Stanford gave a very good reply to the spurious claims made by Fastbraces. I can align the labial segment for most of these cases in three months whilst ignoring all of the other orthodontic considerations. My patients are not in pain and I use gentle forces whichever bracket system I use. Do I now have to call this treatment modality 'Super Quick 90 Day Tooth Straightener' to keep up with the marketing roundabout?

R. Abrahams, Rickmansworth

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Dental education

Reviewing the situation

Sir, we would like to respond to the Taylor *et al.* paper on situational judgement tests (SJT).[1] There is a great deal in the paper which we agree with and we particularly welcome the proposal to create an SJT practice paper. We believe, however, that there are areas that warrant further consideration.

In our original paper we questioned what SJTs are actually assessing.[2] Taylor *et al.* have clarified that they are assessing 'non-academic attributes' and also tell us these inter- and intrapersonal attributes, such as integrity, teamworking and resilience, are professional ones.[1] This is plausible, but, as we cover in our paper, such attributes are only professional when they are directed by the right ethical concerns. It would be possible to show excellent teamworking (say, directed at defrauding a patient) where it is anything but professional.

It could be argued that the expert panel that reviews SJTs ensures that it is the options driven by the correct ethical concerns which are selected. Taylor *et al.* tell us the panel includes training programme directors, educational supervisors and postgraduate dental deans. These professionals will bring a great wealth of practical experience but it is not mentioned if they have specifically ethical expertise. We agree with the authors that ethical and moral judgement are appropriate attributes to work in healthcare, in fact we would say they are essential, but they are only indirectly assessed by SJTs.

We would also agree that a single interview station is unlikely to accurately capture all the professional attributes that SJTs aim to assess. However, we reiterate our belief that Dental Foundation Training (DFT) selection should explicitly assess ethical reasoning and that a third face-to-face station is a plausible way to do so. SJTs do check whether applicants are aware of what sorts of behaviour are expected of a newly qualified dentist. However, we are still concerned that giving 50% of DFT assessment to SJTs gives applicants the impression that they simply need to undertake a set of behaviours without understanding why those behaviours matter.

P. Affleck, M. Wardman, S. Sinclair, R. Adams, Leeds

1. Taylor N, Mehra S, Elley K, Patterson F, Cousans F. The value of situational judgement tests for assessing non-academic attributes in dental selection. *Br Dent J* 2016; **220:** 565–566.
2. Affleck P, Bowman M, Wardman M, Sinclair S, Adams R. Can we improve on situational judgement tests? *Br Dent J* 2016; **220:** 9–10.

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Antibiotic resistance

Correct dosage

Sir, increasing problems with antibiotic resistance mean that doses required to kill bacteria are rising. The most recent impact of this for dental professionals is that the dose of metronidazole recommended for treatment of oral infections has increased to 400 mg three times a day for up to five days, with review at three days. This dose increase follows advice from Public Health England (PHE).[1] The rationale for change and supporting references can be found at the end of the document. Doses for children have also increased. Following publication of PHE advice the Faculty of

General Dental Practitioners updated its online publication on the subject[2] which is freely accessible via the Open Standards page on the FGDP website www.fgdp.org.uk.

Unfortunately, this recommended dose increase has come too late to be included in BNF 72 (available in September 2016 and to be distributed throughout the health service including to dentists with NHS contracts) and BNFC 2016/17 (published August 2016).[3] However, the change may appear online between now and publication of the next paper issue of the BNF in March 2017.

Dentists will also be aware that in 2014 the dose of amoxicillin for oral infections was increased to 500 mg three times a day for up to five days, with review at three days, for all adults and children aged over 5 years old. This dose recommendation has been included in the BNF since September 2014 (BNF 68).

It is essential that dentists are aware of antibiotic dose changes and prescribe in accordance with recognised guidelines to help limit further antibiotic resistance.

C. Randall, Senior Medicines Information Pharmacist, North West Medicines Information Centre/Yellow Card Centre North West

1. Public Health England. Management of infection guidance for primary care for consultation and local adaptation. May 2016. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/524984/Management_of_infection_guidance_for_primary_care_for_consultation_and_local_adaptation.pdf (accessed July 2016).
2. Faculty of General Dental Practitioners (UK). Antimicrobial prescribing for general dental practitioners. 2014, updated June 2016. Available at: http://www.fgdp.org.uk/publications/antimicrobial-prescribing-standards/acute-dento-alveolar-infections.ashx (accessed July 2016)
3. BNF Editor, Personal communication, July 2016.

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OMFS

Gender imbalance?

Sir, I am a female undergraduate and was recently allocated a two week placement in a combined oral surgery and maxillofacial department in a leading hospital in the UK. This has strengthened my understanding of the importance of quick referral for sinister appearing lesions, my ability to closely follow patients' hospital attendances both pre- and post-operative, and the impact trauma and malignancy can have on not just a patient's quality of life but also that of their family.

I respect and admire those in the maxfac speciality, having the patience to complete the long pathway, the intense hours and the retention of immense detail of head and neck anatomy. However, I have not encountered one female maxillofacial consultant and was very disappointed to learn, following further enquiry into the dynamics of the team, that the entire team of maxfac consultants were all male. This posed a serious question: where was the female representation? Undoubtedly women are just as capable as men, so why was there a serious lack of female consultants?

I am therefore writing in the hope that a female maxfac will get in touch and shine some light on the matter. I have gathered that motherhood and this aspiring career do not mix well. However, I believe there must be females out there who have a good balance of motherhood and a maxfac job. I feel that increasing awareness to all dental undergraduates of real life stories of those with families and careers is very important as we are the next generation in this profession. It can become all too easy for women to see the lack of a gender balance in this speciality and then decide it is not for them. I wouldn't be surprised if many did want to pursue this career but believe they'd need to sacrifice motherhood in order to do so – which surely can't be right? Any advice from female consultants out there would be appreciated!

A. Ahmed, Leeds

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An inspiring specialty

Sir, how refreshing to read of a dental core trainee wishing to take up a career in oral and maxillofacial surgery (*A dentist's life*, Vol. 221 pages 54–56) – I too was galvanised by experiences as a specialist trainee in those very same hospitals.

Two observations were the foundations of my research career in the specialty: 'We always see more assault patients in a miners' strike' and 'people with fractures often came from a few licensed premises'. Consequently, the circumstances of maxillofacial trauma and the potential for preventing it became the subject of my PhD, which with my Cardiff team's subsequent research, showed that violence which puts people in hospital is very powerfully associated with unemployment and deprivation.[1] We also found that the police rarely knew about violence in licensed premises and that the use of the unique information available from trauma patients about where, when and how they were injured could cut violence and its huge costs substantially.[2,3] It also became clear from our trials of motivational interviewing that brief advice about alcohol was effective when given to patients having sutures removed in maxillofacial clinics and in other settings.[4]

These and other discoveries were the basis for advocacy for prevention. In the mid-1990s, our *Face of Wales* campaign resulted in a switch initially to toughened and then polycarbonate glasses in pubs. The UK Government was persuaded to include health in its Crime and Disorder Act 1997 to mandate Community Safety Partnerships between the police, local authorities and other services. In 2008, the Home Office adopted information sharing by A&Es (the 'Cardiff Model') to tackle alcohol-related violence. In 2010 and 2016, successive UK governments applied this model to reduce all kinds of violence, supported by a new information standard (ISB 1594), and violence reduction nurses across England.

The delivery of effective alcohol advice was embedded in the NHS in Wales through our *Have a Word* programme; 16,000 professionals have now been trained and the programme adopted by Public Health England. *Have a Word* is helping to ensure that Dental Defence staff screen 140,000 armed forces personnel for alcohol misuse and advise accordingly.

Encouragingly, since the mid-1990s violence has been decreasing. In Cardiff's only A&E in 2002 we saw 80 patients/week who had been injured in violence. In 2016, there are around 30/week. In 2015, in England and Wales, there were 100,000 fewer violence-related A&E attendances than in 2010.[5]

My early feet-on-the-ground experiences also resulted, indirectly, in the Police Science Institute at Cardiff University – inspired by the dental school model, the College of Policing, which in turn was inspired by the Royal College model. A national 'What Works Centre' in crime prevention,inspired by the NICE model, was also established.

Go, dental core trainees!

J. Shepherd, Cardiff

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5. Sivarajasingam V, Page N, Wells J et al. Trends in violence in England and Wales 2010-2014. *J Epidemiol Community Health* 2016; **70:** 616–621.

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