COMMENT

Letters to the editor

Send your letters to the Editor, *British Dental Journal*, 64 Wimpole Street, London, W1G 8YS. Email bdj@bda.org. Priority will be given to letters less than 500 words long. Authors must sign the letter, which may be edited for reasons of space. Readers may now comment on letters via the *BDJ* website (www.bdj.co.uk). A 'Readers' Comments' section appears at the end of the full text of each letter online.

Alveolar osteitis

What's in a name?

Sir, alveolar osteitis (dry socket) is a well-recognised and frequently encountered post-extraction complication resulting from premature disintegration of a blood clot in the extraction socket. The clinical presentation of alveolar osteitis is typically marked by moderate to severe, throbbing pain on the 2nd to 4th day after an extraction; tender, exposed alveolar bone; and halitosis. It is best described as delayed healing and the therapeutic goal is to relieve the patient's pain. However, treatment does not hasten healing.¹ Alveolar osteitis should be managed with irrigation of the extraction socket with sterile saline to remove necrotic debris and placement of an appropriate medicated dressing like Alvogyl. Curettage of the socket needs to be avoided as it may expose the bone further. Persistence of pain may require replacement of the dressing every other day until the pain subsides.

Anecdotal evidence from general dental practice settings across the country suggests that dentists and nurses frequently tend to equate alveolar osteitis with an 'infected socket' and the same diagnosis is often communicated to the patients. This seems misleading and almost invariably prompts patients to request antibiotics. Although there is a small risk that alveolar osteitis may be complicated by secondary infection, this needs to be evaluated objectively rather than assumed by the dental clinicians. Establishing a diagnosis of an infected socket warrants clinical evidence of suppuration and/or soft tissue swelling and erythema, fever and lymphadenopathy. The Chief Medical Officer in England has repeatedly expressed serious concerns regarding widespread antibiotic resistance and has called upon NICE to develop guidance on antibiotic prescriptions.² More recently the WHO has also described a 'post antibiotic era' as a major

global threat and there is a substantial risk of common infections proving to be fatal due to increasing resistance of microorganisms to available antibiotics.³

Given that dental practices also contribute to the heavy load of total antibiotic prescriptions across the country, it is imperative to revisit this issue to restrict the use of antibiotics only to clinical situations where absolutely indicated. Following routine extractions, dental practitioners are more likely to encounter alveolar osteitis than infection which precludes the need for antibiotic prescriptions.⁴ Using your esteemed journal's platform I wish to re-emphasise that alveolar osteitis needs to be managed as delayed healing rather than an infection and this should be communicated accordingly to the patients. This will help reassure patients and minimise their demand (and potentially incorrect prescriptions) for antibiotics.

K. Ali, Plymouth

1. Hupp J R, Tucker M R, Ellis III E. *Contemporary oral and maxillofacial surgery*. Elsevier Health Sciences, 2013.
2. Davies S C, Fowler T, Watson J, Livermore D M, Walker D. Annual Report of the Chief Medical Officer: infection and the rise of antimicrobial resistance. *Lancet* 2013; **381**: 1606–1609.
3. World Health Organization. Antimicrobial Resistance Global Report on surveillance 2014.
4. Lodi G, Figini L, Sardella A, Carrassi A, Del Fabbro M, Furness S. Antibiotics to prevent complications following tooth extractions. *Cochrane Database Syst Rev* 2012; **11**: CD003811.

DOI: 10.1038/sj.bdj.2016.795

Dental education

Colour perception impairment

Sir, I am grateful to the authors of the opinion piece on screening dental students' deficiencies in colour perception (*BDJ* 2016; **221**: 227–228). Not because I agree with their thesis, but because the issue of colour perception impairment (CPI) needs to be aired and better understood. Importantly, proper adjustments should be made to accommodate such impairments. This applies equally to dentists in training and

in employment, because their trainers and employers have a legal duty to do so.

There are very few professions that can genuinely claim such adjustments would be too expensive or onerous, or that their lack thereof would endanger the public. Such thinking is outmoded and very likely discriminatory. Nowadays, around one third of would-be-pilots with a CPI are deemed perfectly safe to fly thanks to new tests which can differentiate the types of CPI.^{1,2} Of note, the blanket ban on 'colour-blindness' in the police force was deemed indirectly discriminatory on the grounds of sex, because its frequency in males is approximately ten times that in females.³ Moreover, a blanket ban does not take into account that there are varying degrees of CPI.⁴

Returning to dentistry, I would take issue with the assertion that colour perception is a core dentistry skill, for several reasons. A skill is an ability that can be taught and learned – clearly not applicable to CPI. Colour-matching is a technical measurement that can be more accurately achieved with instrumentation rather than relying on the human eye (with or without CPI). I cringe that the authors compare impaired colour vision acuity with mental impairment in the debate about professional competence. Therefore, I categorically refute their assertion there is an urgent need to 'determine the relationship between colour vision deficit and dental competence'.

Seeking the wisdom and guidance of our dental regulator sadly does not provide any enlightenment on the subject of CPI, nor indeed the more general issue of adjustments for disabilities. COPDEND, on the other hand, does provide an equality impact assessment on foundation training wherein they assert the model of assessment is seen to be fair and equitable to all disability groups.⁵ (However, I have advised COPDEND that their website system to deliver a written enquiry requires the enquirer to pick out

numbers coloured red from other numbers to create a PIN!)

Most of this debate may soon be moot, as about 80% of CPI cases can have their colour vision corrected by a new invention of CPI-correcting glasses.⁶ It will take time for them to become mainstream, but seeing is believing.

To find really useful, detailed thinking on the subject of equality and diversity in the medical profession, including CPI, I recommend the various guidance documents and information pieces provided by the BMA (I declare a past interest). The resources provide appropriate, concrete help and, most importantly of all, are written with a great deal of humanity.^{7,8}

C. Seddon, Cardiff

1. City, University of London. A new web-based colour vision test. Available at: <http://www.city.ac.uk/health/research/centre-for-applied-vision-research/a-new-web-based-colour-vision-test> (accessed 6 September 2016).
2. Equality Law. New colour blindness test reduces barriers to safety critical work. 5 October 2012. Available at: <http://www.equality-law.co.uk/news/2736/60/New-colour-blindness-test-reduces-barriers-to-safety-critical-work/> (accessed 6 September 2016).
3. Freeths. Could a ban on colour-blind recruits be discriminatory? 21 October 2014. Available at: <http://www.legalrss.co.uk/freeths/could-a-ban-on-colour-blind-recruits-be-discriminatory> (accessed 6 September 2016).
4. Color Blindness. Ishihara Color Test. Available at: <http://www.colour-blindness.com/colour-blindness-tests/ishihara-colour-test-plates/> (accessed 6 September 2016).
5. COPDEND. Satisfactory complete of Dental Foundation Training project equality impact assessment. 5 March 2015. Available at: <http://www.copdend.org/data/files/Downloads/EIA%20Satisfactory%20Completion%20of%20Dental%20Foundation%20Training%20V2050315.pdf> (accessed 6 September 2016).
6. EnChroma Color for the Color Blind. Available at: <http://enchroma.com> (accessed October 2016).
7. BMA. Reasonable adjustments for students and doctors with disabilities. 7 December 2012. Available at: <https://www.bma.org.uk/advice/work-life-support/your-wellbeing/reasonable-adjustments> (accessed 6 September 2016).
8. BMA. Nobody's perfect: how physical characteristics impact on medical careers. 28 January 2012. Available at: <https://www.bma.org.uk/news/2012/january/nobody-is-perfect> (accessed 6 September 2016).

DOI: 10.1038/sj.bdj.2016.796

Are dentists avoiding their metaphorical vegetables?

Sir, I read with interest the results of a survey of dentists in the UK regarding perceived deficiencies in their dental school education.¹

'Soft skills' such as communication, ethics and professionalism were not seen as deficient, and only 10% regarded communication skills to be an important addition. Communication is recognised as a vital aspect of patient centred care. It plays an essential role in patient risk assessment, behaviour modification and integration with the rest of the healthcare team. A large proportion of patient complaints relate to these skills, including a lack of consultation in treatment planning and absence of informed

consent. This indicates there is likely a gap between the level of communication skills thought necessary by the public and the dental profession. This is reflective of the growing tension between professionalism and commercial survival. As such, a picture of potentially imbalanced priorities emerges between the wishes of patients and dentists.

In contrast, there is a growing understanding within the academic sphere of the role of universities in nurturing an ethical, socially responsible profession through curricula design. Dental school directors are in a position to question their role balancing the development of training quality healthcare professionals and the wishes of students. When considering an addition to the curricula a question needs to be asked: should students be given vegetables or dessert?

It is this reader's opinion that the time where schools have students effectively held hostage is better served by promoting the skills which will best improve the quality of care received by patients. Whilst I recognise the important role business skills will have in dentists' workplace quality of life, development of these skills may be better suited to CPD post-graduation. In a time of heavily congested dental curricula it is important for those involved in the education of new dental professionals not to be swayed by the desires of their student consumers, but to keep focused on the wider social picture.

S. Lew, Melbourne, Australia

1. Oliver G R, Lynch C D, Chadwick B L, Santini A, Wilson N H F. What I wish I'd learned at dental school. *Br Dent J* 2016; **221**: 187–189.

DOI: 10.1038/sj.bdj.2016.797

Local area inspection

Arbitrary administrative rules

Sir, I was recently inspected by the Buckinghamshire Local Area Team (LAT) during which a patient's records were examined including a root canal treatment before and after radiographs. The patient had initially presented with pain and there was a draining sinus. The treatment I provided successfully resolved the pain and the sinus healed. Therefore, I was surprised when the LAT inspector informed me that this treatment was 'negligent' because I had not recorded any justification for proceeding to crown the tooth. Crowning a root filled molar tooth is simply following a well-established treatment pathway, and as such is no different to, say, filling a prepared cavity or suturing a surgical incision.

I wondered if this strange finding was a misguided attempt by the LAT to save money (a crown attracts a greater number of UDAs than a root filling alone), but seemingly not, because the other 'misdeemeanour' they picked up on involved a check-up and scale and polish provided for a young teenage girl. The scale and polish was not justified in terms of periodontal disease and therefore – according to the LAT inspector – was 'negligently provided'.

This patient does not have periodontal disease but she likes the feel and appearance of having cleaned teeth. Surely this is something we should encourage patients to appreciate for bringing long term personal and health benefits. Cleaning this young lady's teeth brought no additional payment whatsoever; I would have been paid exactly the same if I had not bothered. I went to the trouble of cleaning her teeth because she wanted them cleaned, and because I believed it was the right thing to do: I was just doing my job.

These two matters (and possibly others that were not discussed at the time) are now to be considered by a disciplinary committee who will decide what action is to be taken against me. This encounter with authority highlights some very worrying issues, which should be of the gravest concern to anybody concerned with the quality of dental services provided in this country. It seems that dentists are no longer judged by what really matters: honesty, competence and personal standards. Instead we are judged according to our compliance with arbitrary administrative rules, and the truly important is ignored.

R. Mackay, by email

DOI: 10.1038/sj.bdj.2016.798

Dental patients

The true value of every appointment

Sir, I'm currently a third year dental student at Peninsula. During my second year of dental school I was given a community engagement project involving young mums. During a dental school visit, I was involved in a simulated dental appointment that was being watched by a young mum who was very anxious of the dentist. The simulated appointment was 10-15 minutes long and was regarding what a normal check-up entails and what instruments are commonly used. We later found out that this individual signed up to see a dentist based upon what they saw at the dental school. This opened my eyes to how much of an impact we can have on a person's life and dental health