Dental practice

Longevity record?

Sir, records I know are there to be broken, but I would like to submit what I think is quite an impressive one.

Though I sold my predominantly NHS practice three years ago, I continue to work there a session a week and after surgery tonight, invited past and present staff for a glass of bubbly to celebrate 40 years to the day that I arrived fresh from a house job at the London to start as probably Britain's most easterly associate. I have been there ever since and hope to continue for some time yet.

When I began, instruments were 'sterilised' in boiling water, gloves were not in use, my principal was reusing needles after leaving them in disinfectant, £12 was the maximum NHS charge, patient records were a couple of lines each visit and our patients were periodically examined by a RDO (Regional Dental Officer) – a nerve racking experience but an excellent practice!

I have a feeling nowadays that young dentists move around quite a bit before they settle down so if indeed this is a record for longevity in a dental practice, it may remain one for quite some time.

P. Williams, Lowestoft

DOI: 10.1038/sj.bdj.2017.195

Oral health

What is gum disease?

Sir, despite our best efforts the UK prevalence of chronic periodontitis has remained at 45%.[1] I believe that many patients are confused about 'what gum disease is', often using this phrase themselves. They report inconsistency in the information and advice given by different healthcare providers and respond better if they understand the potential seriousness of periodontal infection and the consequent inflammatory reaction.[2-4]

As a specialist in periodontology, ten years ago I started using these simplified sentences in my discussions with patients:

- Gum disease is an infection that irreversibly destroys the bone that holds your teeth in place
- When a significant amount of bone has been destroyed your teeth will feel loose or wobbly
- When insufficient bone remains to support your teeth they will start to drift or fall out.

Consequently, my patients readily appreciate the seriousness of their condition and, almost always, express their gratitude for the unambiguousness of the communication. While the statements have a negative tone, once patients appreciate the seriousness of their condition positive tones can be introduced by discussing the benefits of resolving their condition, for example, avoiding bad breath. There are no studies on topic specific words and their influence on patient understanding and compliance but I am hopeful that this letter might encourage this.

H. Ahmed, by email

1. Adult dental health survey 2009 - summary report and thematic series. 24 March 2011. Available at: http://content.digital.nhs.uk/pubs/dentalsurveyfullreport09 (accessed February 2017).
2. Bissett S M, Stone K M, Rapley T, Preshaw P M. An exploratory qualitative interview study about collaboration between medicine and dentistry in relation to diabetes management. *BMJ Open* 2013; **3:** DOI:10.1136/bmjopen-2012-002192.
3. Davis K. Power words in periodontal communication. *RDH Magazine* 2011; **31:** 74. Available at: http://www.rdhmag.com/articles/print/volume-31/issue-9/columns/power-words-in-periodontal-communication.html (accessed February 2017).
4. Davis K. The art and science of effective communication for non-surgical periodontal treatment. pp 58–68. *Continuing Education*, October 2007. Available at: http://www.dentaltown.com/Images/Dentaltown/magimages/1007/DTOct07pg58.pdf (accessed February 2017).

DOI: 10.1038/sj.bdj.2017.196

Dental research

Quality and sustainability

Sir, the dental research community has received continuous support by taxpayers in the expectation that results may lead to significant improvements in the public's oral health.[1] Arguably, this has not happened and the quality and sustainability of dental research does not match that in other health disciplines. The body of literature on dentistry is dominated by observational studies, short-term trials, reviews or technical reports. Reasons cited for the absence of high-quality research are often related to funding issues, lack of research activity of dental faculty, and separations of the full-time dental faculty.

The National Health and Medical Research Council (NHMRC) is the principal funding body for health and medical research in Australia, with an annual budget of AU$700 million. Despite the burdens of poor oral health and increasing dental care spending (AU$9 billion in 2013), oral health is not listed as a National Health Priority Area for NHMRC research funding. Between 2011 and 2015, cancer, mental health, diabetes and cardiovascular disease groups received the greatest proportion of such funding.

Although clinical dentists are the principal leaders of the dental team, their contributions to dental research and peer-review publications are relatively limited.[2] In Australia 85% of dentists practise in the private sector resulting in less time to focus on pursuing scholarly activities or national policymaking. Dental faculty shortages have been reported in various countries with income gaps between academic and private posts and the additional time for preparation for academic careers cited as reasons.[2] Other factors are a risk of losing the job, reduced potential to achieve tenure or promotion as many dental schools demand peer-reviewed publications and a consistent record of funding.[2]

Members of the dental team, in particular, dentists, have a responsibility to advocate for funding equity in dentistry and contribute to closing the gap in oral health. Further evidence-based research addressing oral health disparities and burden of oral diseases is needed as this could guide or encourage national funding agencies to prioritise dental research in their funding plans.

M. Estai, S. Bunt, Y. Kanagasingam, M. Tennant, Australia

1. Bader J. Evidence-based dentistry and the dental research community. *J Dent Res* 1999; **78**: 1480–1483.
2. Oakley M, Vieira A R. The endangered clinical teacher scholar: will this eliminate discovery from the dental school environment? *J Dent Res* 2008; **87**: 200–202.

DOI: 10.1038/sj.bdj.2017.197

Water fluoridation

Is fluoride chemophobia?

Sir, I do wish that when credentialed professionals make sweeping statements about the safety of water fluoridation that they demonstrated that they had actually read the key literature in question. For example, when Dr Reekie writes that there is 'overwhelming evidence that fluoride is safe'[1] he gives no indication that he has read the voluminous evidence (over 300 animal and human studies) that fluoride is neurotoxic – let alone cite an equally voluminous number of primary studies that allows him or anyone else to discount this finding with any confidence. The http://fluoridealert.org/ website contains a complete listing of the over 300 neurotoxicity studies.

While avid promoters of fluoridation might wish to dismiss such efforts as a result of chemophobia, it is actually based on

reading the scientific literature. What some of us are really 'fearful' of, is dental professionals and government officials who feel it is more important to defend this practice rather than to protect the health of citizens from this toxic substance.

P. Connett, Retired professor of chemistry, Senior Adviser to the Fluoride Action Network

1. Reekie D. Fear of fluoride. *Br Dent J* 2017; **222:** 16-18.

DOI: 10.1038/sj.bdj.2017.198

Like a knee in the gut

Sir, having promoted fluoride ingestion for the first 25 years of dental practice, I am sympathetic to Reekie's dilemma regarding education of the sceptical patient.[1] Listening to my 'fearful' patients, I finally read the research for myself. The evidence is like a knee in the gut. Many are ingesting too much fluoride. Benefit is not supported by good science. The evidence of serious risk is rapidly growing. My dental and public health professions would create less fear if we have balanced science based answers.

We should warn patients not to swallow toothpaste, use a tiny smear on a brush for children, and pregnant mothers to be especially careful not to swallow fluoride or fluoride products. Carefully instructing our patients with balanced evidence will raise their confidence in our profession and reduce their fear.

W. Osmunson, Fluoride Action Network, Director

1. Reekie D. Fear of fluoride. *Br Dent J* 2017; **222:** 16–18.

DOI: 10.1038/sj.bdj.2017.199

English language

An Indian view

Sir, English, the universal language on the Internet, has created a global village, brought researchers to the same platform and caused a 'brain drain' from India. The present trend of low English proficiency among dental graduates is a cause of concern, not only when they practise in India but also when they migrate. For primary education, private schools prefer English as medium of instruction while public schools use regional languages; however, centres of higher education follow English. Public school-bred students have to read and listen in English, think and understand in their mother tongue and reproduce the concept in English for assessments. The student often grasps the concept when explained in a regional language but is unable to translate the same in English. Reference books are available only in English and not all scientific terms can be 'Indianised'.

At postgraduate level reference books, journals, publications and conference presentations require proficient English where incompetency can be a handicap. We need to act-in-time to contain the scenario. Forcing a foreign language for higher education can be argued as a form of 'linguistic dictatorship' or 'mother tongue slavery', but English is no longer a foreign language in India. We suggest forming committees with representatives from the Dental Council of India, dental schools, a few bright students, recent graduates and educators to analyse the situation; encourage compulsory and regular use of contemporary English and medical dictionaries and introduce a compulsory six month pre-dental English course; recruit good bilingual faculty; conduct group activities like English reading and promote self-assessment among students.

J. George, Lucknow, India
D. Mandhyan, Bhairwah, Nepal
U. K. Jha, Hazaribagh, India

DOI: 10.1038/sj.bdj.2017.200

Referrals

An orthodontic opinion

Sir, we write regarding the letter *Impacted canines*[1] by M. Wardle. As the authors of a Cochrane review in this area,[2] we urge general dental practitioners NOT to remove the primary canine without an orthodontic opinion. There is evidence that removal of the primary canine might help in some patients; however, other aspects, such as space available and severity of displacement of the permanent canine, are very important considerations. Other concerns include the condition of the crown and root of the primary canine; some have excellent roots and a good long-term prognosis. Extracting such a primary canine in a patient that is not suitable for lengthy treatment with fixed appliances (due to either poor oral hygiene or motivation) might leave the patient with an unsightly gap, when they could have had their primary canine *in situ* for decades. We believe that the majority of specialist orthodontists, despite long waiting lists, will triage their referrals and see a patient sooner, if there is good reason.

P. Benson, N. Parkin, Sheffield

1. Wardle M. Impacted canines. *Br Dent J* 2017; **222:** 2.
2. Parkin N, Furness S, Shah A *et al.* Extraction of primary (baby) teeth for unerupted palatally displaced permanent canine teeth in children. *Cochrane Database Syst Rev* 2012; **12:** CD004621.

DOI: 10.1038/sj.bdj.2017.201

A utopian aim

Sir, I read with interest P. Raftery's letter regarding apicectomy.[1] I was intrigued by his contention that specialist endodontists be considered for NHS apicectomy referrals.

His utopian aim for a service which can provide the staffing, ultrasonic equipment and magnification to boot is commendable, albeit for an increasingly uncommon procedure.

As a staff member in a maxillofacial unit which can provide apicectomies, my colleagues and I are cognisant of the 'gold standards'. Often in our service the majority of the referrals do not meet the criteria for an apicectomy. As a result we advise the patient on the myriad other treatment options, rather than blindly proceed with a hopeless apicectomy using our 'stone age non-ultrasonic implements'.

Our department is paid £134 per apicectomy by the NHS. If Mr Raftery can usher in a revolution in NHS apicectomy treatment for this fee he is gladly welcome to it.

D. Shiels, Chesterfield

1. Raftery P. Referrals: Apicectomy. *Br Dent J* 2017; **222:** 2.

DOI: 10.1038/sj.bdj.2017.202

Social media

Undermining trust

Sir, I would like to comment on Dr Ilona Johnson's insightful response to my letter.[1] I accept most of her points but I am concerned about part of Dr Johnson's conclusion. The suggestion was that dental students/professionals should manage their public image, '… in order to engender and maintain trust in our profession'. Presumably, the concern is that if people saw how they actually behaved they might not trust them. Notwithstanding GDC guidance, this seems open to a charge of hypocrisy and actively undermines trust.

P. Affleck, Leeds

1. P. Affleck. Social media: Professionalism. *Br Dent J* 2017; **222:** 68–69.

DOI: 10.1038/sj.bdj.2017.203