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.

Oral health

Treating refugees

Sir, the article titled *Personal account: A drop of dentistry in the jungle* (*BDJ* 2016; **220:** 160–163) highlighted the appalling conditions in the refugee camps set up in Calais as well as providing us an insight into the poor oral health status of many of the camp's residents. As dental students this motivated us to make the journey from Cardiff to Calais with a team of qualified medical and dental professionals with the aim of providing dental aid.

As we arrived by the camp, the mood in the car subtly shifted to a tense silence as we saw smoke masking the entrance. With many media outlets reporting that the camp was in the process of being completely demolished, all residents having been cleared, news of fires and riots spreading, there was an unspoken anxiety about what we might encounter. Entering the 'jungle' was almost dream-like: the blazed periphery gave us a view into the vast landscape which once had many thousands living in such horrid conditions. Contrary to media reports we drove past hundreds of residents until we came to a halt somewhere in the depths of the camp, where nearby, teenage boys were playing a game of volleyball.

We decided the best way to maximise patient treatment would be to set up a basic triage system equipped with three plastic chairs we spotted by a nearby tent. As students, our duties involved distributing toothbrushes and toothpastes, providing oral hygiene instructions, helping to effectively maintain the triage system and mixing GIC or Kalzinol.

The clinicians treated over 100 cases of acute dental emergencies, with many patients in pain from toothache that they had been suffering from for weeks. The majority of dental treatment involved excavating and temporising large carious lesions; however, we also came across complicated and uncomplicated crown fractures in children caused by trauma whilst playing. A young lad with acute necrotising ulcerative gingivitis also presented but we could only provide treatment with local measures by carrying out hand scaling and oral hygiene instructions. The most perplexing case we encountered all day was a lady with her buccal maxillary gingivae coloured dark blue but with no obvious signs of pathology; however, after eventually finding a translator we were reassured it was a cultural practice of tattooing the gums! The reality of the poor oral hygiene levels amongst the camp was now fully understood as almost every patient presented with carious lesions with resulting pain. It was heart-breaking knowing we could only provide a limited amount of treatment.

Besides the dentistry, it was touching to connect with the stories of struggle and sacrifice of the camp's residents, many of whom were fleeing from war and persecution. As the Calais camp has now been demolished, we hope our friends have now been reallocated to better living conditions and are provided with the very basic human needs we all require.

We would urge all dental professionals to partake in such charitable causes and offer their skills in the service of humanity.

S. M. Hussain, H. Sheikh, A. Amir, A. Al Hassan, by email

DOI: 10.1038/sj.bdj.2017.843

Unsupported conclusions

Sir, we read the article entitled *Motivational interviewing in general dental practice: A review of the evidence* by E. J. Kay, D. Vascott, A. Hocking, and H. Nield (*Br Dent J* 2016; **221:** 785-791), which presents a systematised review of the evidence in relation to motivational interviewing (MI) in dental practice. This approach to changing oral health behaviours and habits is an emerging and significant theme. Considering their proposed objective, the authors concluded that the MI technique has the potential to benefit patients with poor oral hygiene and suggested that MI training for oral healthcare professionals can be added to the established set of practices. However, we observed that only two of the eight articles included are intervention studies that use the MI-based approach specifically to treat patients with periodontal disease.[1,2] Of the remaining studies, one addresses the cost-effectiveness of the intervention[3] without analysing clinical results as the main outcome. Another study[4] claimed to apply an MI-based approach, but according to the methods described it does not fall under the assumptions and techniques described by Miller and Rollnick.[5]

Three articles did not use MI-based approaches,[6-8] and one is a qualitative study[9] that only describes the approach used by dental hygienists. Lastly, one study is not cited in the references, making it impossible to determine whether the intervention involved MI or not.

The evidence found by the authors does not support the conclusions, neither regarding better oral health among patients, since the studies included did not synthesise sufficient and adequate evidence for this conclusion, nor professional training, given that none of the articles assessed this aspect for oral health teams. Moreover, we believe that MI is not centred solely on providing additional skills and techniques for clinical practice, as proposed by the authors. MI involves changing professional attitudes and conduct to establish a dialogue about change, promoting self-efficacy and helping patients change their unhealthy oral health behaviours. It is important for readers to understand that MI is a specific approach, with assumptions and techniques described by Miller and Rollnick, and should not be confused with other behavioural approaches.[10] There is more robust evidence available to understand the

Official journal of the British Dental Association.