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.

Oral health

Learning styles

Sir, we may not be delivering oral hygiene instruction as effectively as possible. The majority of us attempt to educate our patients pedagogically; however, we must transition to the andragogical format of teaching to develop patients' knowledge and behaviour and ultimately improve patients' oral hygiene.

A learning style is defined as 'characteristic cognitive, effective, and psychosocial behaviours that serve as relatively stable indicators of how learners perceive, interact with, and respond to the learning environment'.¹ Basically, it is an individual's preferred method of learning.

The VARK classification describes learning styles by dividing individuals into learning characteristics by use of questionnaires: Visual (pictures, movies or diagrams), Auditory (music or discussion), Reading/Writing (lists, reading books or taking notes) and Kinaesthetic (experiments or hands-on activities) sensory modalities, giving a score for each separate modality.² It is recommended that we tailor the delivery of an individual's education to enhance learning based on this.

This has been used widely in dental education not to predominantly teach students in their preferred method but rather alter their delivery methods to give students with different learning styles a more conducive learning environment.³ It has been shown that tailoring health information to patients with hypertension according to their literacy and learning preference will improve uptake of information and hopefully improve understanding and health.⁴

Although various methods of oral health education have been shown to be

effective, one thing which is clear is that no one delivery method suits all patients.⁵ Therefore, I wish to encourage us to personalise oral health education to the individual patient. For example, we could preferentially provide education in the form of a leaflet for patients in the reading sensory modality, deliver a more practical instruction for kinaesthetic patients and provide a more visual leaflet/video format for visual learners.

Doing a full questionnaire for every patient may not be practical; however, developing quicker techniques which would easily allow us to identify a patient's learning preference would allow us to adapt our delivery style.

C. P. Devine, by email

1. Curry L. Learning preferences and continuing medical education. *Can Med Assoc J* 1981; **124**: 535–536.
2. Fleming N D, Mills C. Not another inventory, rather a catalyst for reflection. *To Improve The Academy* 1992; **11**: 137–155.
3. Murphy R J, Gray S A, Straja S R, Bogert M C. Student learning preferences and teaching implications. *J Dent Educ* 2004; **68**: 859–866.
4. Gluse N B, Koonce T Y, Storror A B, Kusnoor S V, Ye F. Using health literacy and learning style preferences to optimize the delivery of health information. *J Health Commun* 2012; **17**(Supp 3): 122–140.
5. Yoder M E. Preferred learning style and educational technology: linear vs. interactive video. *Nurs Health Care* 1994; **15**: 128–132.

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You're on camera

Sir, I think I speak for many when I say most of our patients could improve their oral hygiene. No matter how much we tell them, still they return at their next check up having never picked up an interdental brush, with that red band of inflamed gingivae hugging calculus and soft plaque deposits. So instead of telling them, why not show them?

Clinical photography is a great aid many are not using; I have found it to be key in engaging and motivating patients. Showing

patients and explaining what they see aims to educate and engage them. They are used to seeing pictures in the media of perfect clean teeth so why not take a picture of theirs to show them the difference rather than just being told 'you need to floss'?

Take a photograph at each check up for comparison. Has there been an improvement? If so, where? If not, why? Photographs act as a clinical record, which helps to document whether the patient is truly engaging with treatment. This allows the clinician to gauge the level of compliance, can be helpful for decision-making and can offer support in litigation, by being able to clearly and accurately document continually poor plaque control and lack of patient engagement.

Overall I feel photography is a powerful tool we have at our disposal for patient motivation, engagement and education. It is not just for 'before and afters' or our own egos.

N. Parten, by email

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Orthodontics

Making false promises

Sir, it is not uncommon for dental practitioners to see adolescent patients in whom there is either a developing or established malocclusion associated with a significant underlying skeletal discrepancy. This may result in any combination of a marked Class II or III incisor relationship, significant facial asymmetry, and/or problems in the vertical dimension leading to a deep overbite or anterior open bite. These conditions may prompt the practitioner, quite rightly, to refer the patient to a specialist orthodontist or directly to the consultant-led hospital service for advice and/or treatment. In some cases, orthognathic

treatment, combining orthodontics with orthognathic surgery, may be included in the treatment considerations, leading to onward referral to a hospital multidisciplinary team (MDT).

At the multidisciplinary clinic, the team must weigh up all the treatment options and whether or not the various approaches would satisfy the patient's motivations and expectations. Fundamental to this process is a consideration of the risks and benefits associated with each approach before putting these to the patient. Unfortunately, it is our experience that an increasing number of patients are being referred where there are significant risks of providing orthodontic treatment (eg, poor oral health), or surgery (eg, adverse soft tissue factors and/or potential for relapse) or where there are unproven health benefits (eg, correction of speech problems or TMJ disorders) and these concerns mean that acceptance for this form of treatment cannot be justified. Explaining this to patients who have been told, or even promised, by previous clinicians that they need orthognathic treatment once they have stopped growing in order to satisfactorily treat their problem, can and does lead to extremely distressing situations for all concerned.

Whilst some patients will accept the decision, a significant number become distraught or aggressive, citing previous clinicians' promises as the basis for these feelings. Patient complaints are increasing and of serious concern. Good communication with patients and their parents is paramount at every patient contact and sometimes we fail to appreciate how simple comments or suggestions can have long-lasting effects on patients. It is our belief that clinicians should be reminded that, when faced with these clinical problems, carefully worded advice to patients is vital. Patients and parents can be advised that orthognathic treatment is a potential treatment option but should be advised that no decision can be made as to the appropriateness of this until the patient has been fully assessed by the MDT and on no account should promises for future treatment be made. Of course what patients and parents might hear from a consultation may differ from what clinicians have actually said; so it is important to emphasise that no future treatment is guaranteed at this stage.

Whilst forming only part of the overall diagnosis and assessment of patients, referring general practitioners and specialists may find the Index of Orthognathic Functional Treatment Need helpful when considering whether to refer a patient for consideration for treatment.¹ This is based on a risk/benefit analysis and operates in a similar way to the Index of Orthodontic Treatment Need (IOTN) with which referrers will already be familiar.

*N. Hunt, S. Cunningham, T. Lloyd, J. Shute,
by email*

1. Ireland A J, Cunningham S J, Petrie A et al. An index of orthognathic functional treatment need (IOFTN). *J Orthod* 2014; **41**: 77–83.

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Never events

Recent update

Sir, we are writing to inform colleagues of the recent update to the NHS Never Events list. According to NHS Improvement, Never Events are defined as 'serious incidents that are entirely preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers'.¹

A list of eight core Never Events were originally implemented in 2009 by the National Patient Safety Agency. The most recent revision of the Never Events list, in January 2018, categorises incidents as those related to 'Surgical', 'Medication', 'Mental Health' and 'General' domains.

Pertinent to dentistry, the latest update includes the incorrect extraction of primary teeth as a wrong site surgical Never Event. It is, however, a matter of some contention that the incorrect extraction of primary teeth is only classified as a Never Event if the extractions are completed under general anaesthesia. The justification provided for this is that 'the extraction of primary (milk) teeth is extremely unlikely to result in severe harm/death unless it is done under a general anaesthetic when the potential risks of anaesthesia could apply'.²

For interest, also relevant to dentistry is the previous inclusion on the list of wrong site pain relief blocks, biopsies, implants that differ from that specified in the procedural plan, and teeth extracted in error that are immediately reimplanted. Notably,

the list excludes wrong site surgery due to incorrect referral letters; of particular relevance perhaps to those who frequently request the extraction of teeth for orthodontic purposes.

S. McKernon, L. Gartshore, Liverpool

1. NHS Improvement. Revised Never Events policy and framework and Never Events list 2018. January 2018. Available at: <https://improvement.nhs.uk/resources/never-events-policy-and-framework/#h2-revised-never-events-policy-and-framework-and-never-events-list-2018> (accessed April 2018).
2. NHS Improvement. Previous versions of the Never Events policy and framework and Never Events list. January 2018. Available at: <https://improvement.nhs.uk/resources/never-events-policy-and-framework/#h2-previous-versions-of-the-never-events-policy-and-framework-and-never-events-list> (accessed April 2018).

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Editorial decisions

Cover art defended

Sir, I was taken aback by the acerbic criticisms of Professor Sperber of Canada regarding the cover art used on the *BDJ*.¹ Both the previous series of commissioned images based on dentistry in literature and the current highlighting art from dental health campaigns are part of the way society sees us and of our dental history. These latter in particular reflect the social history and graphic designs considered appropriate by our colleagues working during that period.

The dental health campaigns of the twentieth century have important historic significance and it is timely and appropriate for them to be used as cover images even if they too may on first glance be condemned as 'discreditable' and 'comedic'. Professor Sperber refers to a more ancient dental history, but would he also dismiss the typically comical cartoons of Thomas Rowlandson depicting the barber surgeons? Dentists who graduate in the twenty-first century will not have seen the dental health posters of the previous century. Calls to dismiss any aspect of our rich and illustrious dental history are to be robustly resisted. I applaud the Editor of the *BDJ* for giving front cover prominence to historic posters. Indeed as the Honorary Curator of the BDA Dental Museum and Editor of the *Dental Historian*, I would encourage more of the same.

M. Wilson, by email

1. Sperber G. Editorial decisions: Diminishing credibility. *Br Dent J* 2018; **224**: 197.

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