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.

Orthodontics

Orthodontics vs orthodontiya

Sir, orthodontics is the conventional modality for correcting crooked teeth around the world, but I would like to draw your readers' attention to a Russian variation, invented by the Soviets in the 1980s: 'orthodontiya'. This method was not able to develop much because of the economic collapse of the USSR but after the fall of the Iron Curtain, orthodontiya was soon turned into the chaotic process of selling orthodontic appliances directly to the public.

All the appliances appeared to be wonderful for both doctors and patients, and 'treatment' was often started without any diagnostics and almost always with significant legal violations. Even though many post-Soviet doctors started to proclaim themselves professors and PhDs in orthodontiya, the blunt truth was that none of them had even graduated from a full-time postgraduate programme in orthodontics. Nevertheless, since the late 1990s, post-Soviet 'orthodontic pioneers' started to establish their own postgraduate programmes, which up to the present day do not meet the requirements for postgraduate education by the World Federation of Orthodontists, the most credible international orthodontic organisation. Furthermore, there are no research data to suggest that brave new orthodontiya is as effective as conventional orthodontics.

Unfortunately, if a country does not have a credible specialty for carrying out orthodontic treatment, patients are destined not to receive the level of treatment they deserve. They require reliable orthodontists. Today we have limited ways to assess the skills of an orthodontist – we have to look at the results that are achieved. An orthodontic board is an organisation that assesses the skills of an orthodontist by scrutinising the diagnostic records, treatment plans and results of treatment; several of these have been established by experienced orthodontists around the world. Fortunately, the European Board of Orthodontists provides its services to all European orthodontists including Russians, thus providing an opportunity for an orthodontist to achieve Board Certification. I encourage every dentist who is referring patients to Russia to inform them about this issue. By choosing a board-certified orthodontist a patient can be reassured that treatment will be done by an experienced specialist in accordance with contemporary internationally-approved protocols.

A. Ditmarov, Russia

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Dental education

Should dental schools consider a curriculum change?

Sir, it only just occurred to me recently, but there appears to be a potential flaw in the dental curriculum. If you consider the number of dental schools in the UK and the total number of graduates that they produce on a yearly basis, you are looking at approximately 800 dental graduates every year.

Almost every one of these graduates will enter a dental foundation training programme. Some may choose to go into core training posts in various hospitals, like myself. However, the majority will choose to work full time in a dental practice as an associate.

Some of these dental practices will require all the associates they employ to manage their own stock, as well as paying for any private materials.

Furthermore, many dental associates out there often aspire to, one day, owning their own practice.

Considering all this, would it therefore not seem reasonable that universities should incorporate some form of business aspect within the dental training curriculum? Unfortunately, many of us who don't have any experience or knowledge of managing small businesses will probably make many mistakes, resulting in numerous financial losses along the way. Would it not be reasonable for UK dental schools to assist in minimising these potential pitfalls by preparing UK dental graduates for life as either an associate or a practice owner?

If not part of the core curriculum, making it an optional module at the very least will allow those who aspire to work as an associate, or even one day manage their own practice, to have some foothold in what is already proving to be a very competitive and costly market to enter.

W. Idoo,
Dental Core Trainee OMFS, Blackburn

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Dental recruitment

Acute shortage of clinicians

Sir, I read with interest your feature in a recent issue entitled 'The Dental Recruitment Crisis' (*BDJ* 2018; **224:** 472–475). At mydentist, we recognise the acute shortage of clinicians nationally and the significant impact this is having on the ability of patients to access NHS dentistry. We are doing everything we can to address these challenges.

Yes, we must continue the public health initiatives that are raising awareness of tooth decay, improving oral healthcare, and reducing the need for expensive emergency dentistry. But we must also invest in training in the UK, so we can solve the recruitment crisis in the long term, and look overseas – to the EU and beyond – to attract the best professionals from around the world to practice dentistry here in the UK.

The difficulties faced by ORE dentists wanting to work in the UK, such as Anna

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Julin John who was interviewed in the feature, are severe and it often extremely difficult for them to secure the necessary mentorship to practise.

At mydentist, we are proud that we have more than doubled the number of mentors over the last year and now have around 400 in our scheme. That has been achieved through actively promoting the benefits as a means of combining professional development with helping the next generation of UK clinicians. We've already been in touch with Anna and spoken with her about opportunities to join us as a mentee.

Recruitment challenges are particularly significant in remote areas of the country, leaving patients unable to access NHS care. To address this we are simply asking dentists what they want: we want to work with dentists to create a package that suits them, their families and career aspirations to encourage them to settle in these locations.

Finally, several of the dentists in the feature noted their inability to spend time with patients with the pressures of delivering contracts, regulation and paperwork. Through our network of clinical support and central operations, we try to relieve our dentists of as much of this as possible, leaving them able to do what they do best: treat patients.

While we await details of the new NHS contract, and with the uncertainty of Brexit, we expect recruitment to remain a challenging issue. But, with the steps we've taken we believe we can create attractive opportunities for dentists wherever they are from.

T. Riall,
Group Chief Executive,
Integrated Dental Holdings (IDH)

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Public perception

Dental imaging?

Sir, I recently saw the film *'Three Billboards Outside Ebbing'* and was deeply impressed with the depth and complexity of all of the main characters. None of them are flawless but all had human faults and redeeming features. So the characters took time to develop within their three dimensions. All except one, that is:

There was a small but significant cameo role for a 'fat dentist'. The fat dentist was a bigoted, two-dimensional character, not even worthy of a name, who swiftly got his comeuppance. No one was sorry and the plot had no room for redemption for him.

Am I alone in thinking that all on-screen depictions of dentists show us to be either reprehensible or laughable characters? Notable screen dentists appear in film in *The Rocky Horror Show, The Hangover* and *Marathon Man* and on the small screen in *Butterflies*, *My Family* and *Mr Bean*. The characters in *The Hangover* and *My Family* are merely hapless, and in *Mr Bean* he is a buffoon. But in *Marathon Man*, *The Rocky Horror Show* and *Three Billboards* the dentists would be found guilty of serious professional misconduct.

I accept that dental experiences can generate true humour but I cannot think of a single screen depiction of a dentist as the upstanding, professional member of a community that I recognise in all of my colleagues. Have I missed something or am I being overly sensitive?

J. A. Woodcock, Chalfont St Giles

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Pharmacology

Paracetamol prescribing

Sir, I read with interest the recent article '*Dental pain management – a cause of significant morbidity due to paracetamol overdose*'(*BDJ* 2018; **224:** 623–626). Working in secondary care I am continually surprised by the number of patients admitted to hospital with paracetamol overdoses related to toothache.

For dental colleagues working in secondary care managing inpatients, it is important to consider dose banding with regards to prescribing intravenous paracetamol. Within the trust in which I work this issue has been highlighted as a priority improvement for patient safety. This was implemented after a number of incidents in which patients were incorrectly prescribed intravenous doses of 1 g paracetamol. Unfortunately, some of these patients developed hepatic impairment and were admitted under critical care.

For patients who cannot take paracetamol orally and require intravenous paracetamol, it is important to consider a patients weight and hepatic condition when prescribing. The BNF currently states that patients under 50 kg or who have risk factors for hepatotoxicity should have 15 mg/kg every 4-6 hours to a maximum of 60 mg/kg per day.[1]

Preferably, paracetamol should be given orally whenever possible and patients should be weighed on admission to hospital to aid with dose banding. If intravenous paracetamol is prescribed then it should be switched back to oral at the earliest opportunity.

N. Horisk, by email

1. Joint Formulary Committee. *British National Formulary* (online). London: BMJ Group and Pharmaceutical Press. Available at http://www.medicinescomplete.com (accessed 12 May 2018).

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Antimicrobial resistance

Antimicrobial prescribing: the work continues…

Sir, antimicrobial resistance is an increasingly important consideration when managing systemic or localised infections. Individuals prescribed an antibiotic develop bacterial resistance to that antibiotic,[1] so unnecessary use should always be avoided. Research has suggested that up to 80% of antibiotic use in general dental practice may be inappropriate.[2] In 2015, a statutory duty on healthcare providers in England was introduced to ensure appropriate antimicrobial use.[3]

With this in mind, Health Education South West now requires its foundation dentists to conduct an antibiotic prescribing audit. Prescribing data from the 80 foundation training practices were collected over a 3-week period during 2016/17. Over three-quarters of the 1,127 antibiotic prescriptions were associated with four clinical diagnoses: acute apical infection (n = 518), pericoronitis (n = 171), acute periodontal abscess (n = 166) and irreversible pulpitis (n = 36).

Pain and/or localised infection were the reason for 46% of all prescriptions; notably neither is an indication for antibiotics in FGDP(UK) guidance.[4] Similarly, antibiotic-only treatment plans are rarely indicated, yet accounted for nearly half (48%) of the prescriptions in this audit. So while prescribing quality was found to be somewhat better than that published by Cope *et al.*,[2] most (60%) were still found to be inappropriate in terms of clinical indication, antibiotic type, dose, frequency or duration when assessed against FGDP(UK) guidance.

That many clinicians don't follow published clinical guidelines is well known. One of the reasons, according to Gabbay and LeMay, is that clinicians rely instead on own personal 'mindlines': internalised, tacit guidelines, collectively reinforced mainly by

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