

Letters to the Editor

Are you burnt-out or are you merely frustrated?

Could this modern phenomenon known as 'burn-out' relate to a form of frustration? Which, if understood and resolved, could stop the high attrition rates seen in NHS staff. Burn-out is thought to result from long-term unresolved job stress.¹ However, my preliminary data, on adult-learning (AL) in dental professionals, suggests a need to rethink the current interventions and strategies.

Understanding what knowledge is and how to use it may turn out to be AL.² Dentists can choose from three approaches and this may be contributing to a three-way conflict in general practice, leading to 'frustration', known as 'burn-out'. To explore this phenomenon, this letter discusses, in context, the background literature; next, proposes the reasons for frustration, and considers the implications of this study's findings.

Adult-learning seems to go beyond the mere transfer of *new* knowledge, found in pedagogy, and could be associated with dental professionals starting to deconstruct their existing knowledge and starting to *use* it, instead.³

Knowledge is accepted as being made up of three elements⁴ and each element may be associated with a method of justifying (Figure 1).² If dentists, potentially, are ALs and prefer one way of using knowledge over another, there could be a three-way conflict. Could this explain why some individuals are getting frustrated?

My personal experience is that propositional justification, known as truth or EBD, is taking precedence in primary care. Truth alone is not knowledge and it is not absolute.² Hence, I believe that this is leading to job-related stress and should be renamed job-related frustration, specifically associated with interactions with patients and colleagues.

To follow, I believe that

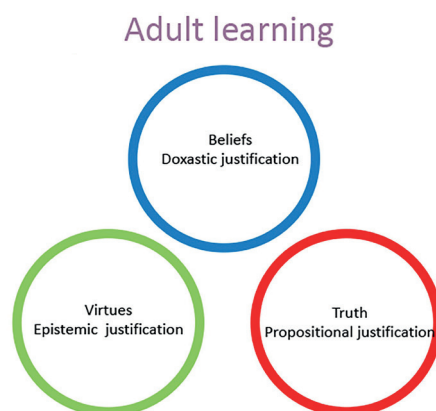


Figure 1. The three justification methods.²

dentists start off 'using' their preferred approach of justifying, but those around them may be using one of the other two approaches, such as patients and colleagues, causing potential conflict. Formal teaching on this, understanding the nature of knowledge, does not usually begin until Masters and PhD level, and it is often incomplete.⁵ Interestingly, to compound the problem, candidates being taught this do not often return to the frontline primary care setting to share this learning with colleagues. Put simply, we need all three elements for knowledge, and 'truth' should not take precedence.

So, I believe that CPD must change and start to incorporate AL, which is set in epistemology and not pedagogy principles. We must either start teaching the nature of knowledge in CPD or restricting anyone in leadership, supervisory or educational roles in the NHS to those who have had thorough training on this subject, as I believe that this is the only way to reduce workplace frustration and staff attrition.

To conclude, as an educational supervisor, I am concerned that this dominance of thinking related to only the truth domain is at the detriment of knowledge, which requires all three in equal measures. Hence, thinkers who do not naturally prefer using just 'truth' as a method of justifying, like me, are finding themselves

isolated and misunderstood on the frontline. CPD must start to address this problem of AL and ensure that all supervisors understand this concept, known as epistemology, or I am afraid that workplace burn-out will continue to increase as the trend continues to follow this one type of thinking at the detriment of knowledge on the frontline.

For further information please get in touch.

Deborah Martin
(debbie_2383@hotmail.co.uk)

References

1. Freudenberger HJ. Staff burn-out. *J Soc Issues* 1974; **30**: 159–165.
2. Martin D *et al*. The case for understanding how health professionals justify clinical decisions to their patients: adult learning principles. 2019.
3. Hartree A. Malcolm Knowles' theory of andragogy: a critique. *Int J Life Educ* 1984; **3**: 203–210.
4. Chappell SG. *Plato on Knowledge in the Theaetetus*. 2005.
5. Gettier EL. Is justified true belief knowledge? *Analysis* 1963; **23**: 121–123.

Banish the bane or face the ghastly consequences: an unusual report on oral submucous fibrosis

Oral submucous fibrosis is a disease predominantly limited to the Asian countries, especially the Indian subcontinent. However, with an ever increasing Asian population in the UK, this disease has contemporary relevance and dentists should be aware of the factors which can predispose to it, even at an early age.

There are only a few reported cases of oral submucous fibrosis in children. A 12-year-old boy presented with complaints of restricted mouth opening and burning sensation in the oral cavity for 6 months. He reported of chewing about 10 packets of gutkha for 6 years. A conspicuous blanched appearance of labial and buccal mucosae and hard palate was observed (Figure 1).



Figure 1. Intra-oral view showing blanched appearance of buccal mucosa and the pterygomandibular region.



Figure 2. Intra-oral view showing restriction of tongue movement.

Tongue movements were reasonably restricted and the patient was unable to bring the tip of the tongue in contact with the hard palate (Figure 2). Dense, fibrotic bands were palpable in the buccal mucosa and the anterior fauces. A diagnosis of oral submucous fibrosis was made based on these features.

The patient was working as a domestic help in a suburban middle class household and he reported only because his employer had also visited the dental clinic for a check-up. He had only completed his schooling up to first grade when he was abandoned by his parents due to extreme penury. He developed the habit of gutkha chewing as it provided a euphoric perception and also satiated the

appetite at little cost. It has been suggested that the interplay between such complex socio-economic factors in the South East Asian region increases the probability of addiction to gutkha chewing in the pre-teen years.¹ To compound matters, illiteracy doesn't help as the mandatory statutory warning imprinted on the gutkha packets remains unread by many. The authors feel that a detailed study to ascertain the prevalence of oral submucous fibrosis in the children of lower socio-economic groups must be undertaken in a country like India where poverty, illiteracy and child labour act together to enhance the vulnerability of the young. The gutkha industry in India is worth billions of rupees so the situation is unlikely to change unless this hazard can be reined in somehow. However, if prompt remedial measures are not taken, the day is not far off when cases like the present one become the norm rather than the exception.

Compliance with Ethical Standards

Conflict of Interest: The authors declare that they have no conflict of interest.
Informed Consent: Informed consent was obtained from all individual participants included in the article.

References

1. Tobacco Free Initiative, World Health Organization. Tobacco and youth in the South East Asian region. *Ind J Cancer* 2002; **39**: 1–33.

Aditya Patney, Consultant Oral and Maxillofacial Radiologist, Mahajan Imaging, New Delhi, India

Amar A Sholapurkar, Head of Department of Oral Radiology, James Cook University, PO Box 6811, Cairns, Queensland – 4870, Australia

Keerthilatha M Pai, Professor and Dean, Manipal College of Dental Sciences, Manipal, India

Stafne's Idiopathic Bone Cavity (SIBC)

We would like to report on a case that was referred to our Oral and Maxillofacial Surgery department. A fit and well 40-year-old male was referred by his general dental practitioner regarding a radiolucency associated with the lower left premolar region. This was otherwise asymptomatic

and the LL4 and LL5 were said to be vital. A panoramic radiograph confirmed the presence of a well-defined and corticated radiolucency in the lower left premolar region (Figure 1).

Clinically there was no intra-oral abnormality; the lower left premolars were non mobile and vital. A CT scan was requested to obtain more detail. This revealed a depression of the lingual left side of the mandible 5 x 10 mm in size with the roots of the lower left premolars just lateral to this lesion. The inferior dental neurovascular canal was sitting immediately inferiorly to the lesion. The lesion was described as potentially being a Stafne's Idiopathic Bone Cavity (SIBC). As per previous literature,¹ an MRI scan was performed, so as to investigate for any involvement or pathology associated with the adjacent salivary gland tissue (likely sublingual) which could be associated with this bone defect.

The MRI scan revealed that the sublingual gland was in close proximity with the lesion, otherwise the remaining soft tissues were normal. Given this information, a SIBC was confirmed, therefore a surgical exploration was contra-indicated as this potentially could damage the premolar apices and the mental nerve for no clinical benefit.

A SIBC is a developmental defect. It has also been described as a pseudocyst without an epithelial lining.² Their prevalence is <0.5% and they typically occur at the angle of the mandible below the inferior dental neurovascular canal³ with the appearance as described. It is postulated that they are caused by compression of the lingual cortical plate from adjacent salivary gland tissue.⁴ When these have been examined for histopathology, more often than not they have been found to contain salivary gland tissue.^{4,5} The management of a SIBC is conservative.

In summary, although unusual and unexpected, this finding should be highlighted to our colleagues, especially as SIBC in the mandibular premolar region has been described⁶ and therefore considered in a differential diagnosis whenever there is an apparent well corticated radiolucency involving the apices of otherwise vital and asymptomatic teeth. Although more detailed imaging will confirm the diagnosis, it may not always be necessary if the suspicion for SIBC is high.