et al. addressed that people with type 2 diabetes are more likely to rate their oral health as poor.[4] This association is stronger among those with lower education levels. Their study suggested that socioeconomic factors may influence the relationship between diabetes and oral health.

Tabesh *et al*. studied 200 type 2 diabetes patients, finding a significant correlation between oral health-related quality of life (OHRQoL) and the severity of xerostomia.[5] Factors such as age, denture wearing, disease duration, and diabetes management were also significantly associated with OHRQoL. The findings suggested that treating both diabetes and oral health issues like xerostomia is crucial for improving OHRQoL in these patients.

These studies continue to suggest a strong link between oral health and diabetes.

Y. Takefuji, Tokyo, Japan

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Oral health education

Education of dental patients

Sir, it is disappointing that there is little or no information regarding education of dental patients.

On establishing a new dental practice in 1988, it contained three rooms. My dental surgery, a dental hygiene surgery, and a preventive dental unit. Initially, all the patients were seen in my surgery, but with time I employed a dental hygienist.

My initial dental nurse was interested in adding to her qualification. She was encouraged to learn about dental education. On qualifying, she ran the PDU.

My schedule was organised such that extra time was allowed for procedures. This enabled me to, for example, give a patient an injection for a procedure in my surgery, leave them with my dental nurse, while I visited either the PDU or the hygienist surgery.

The PDU gave the opportunity to examine the child's teeth and mouth without them sitting in the dental chair. It also gave me the opportunity to emphasise the importance of proper toothbrushing. The dental health education ensured the parent knew how to supervise the child's toothbrushing at home.

In the hygienist surgery, I was given a verbal report of the condition of the patient's oral health. Extra time ensured the hygienist could check and educate the patient in dental health. After my examination, I could emphasise the importance of achieving and maintaining good oral health.

With time it was apparent that the patients spent more time in the hygiene surgery or PDU than they did in my surgery.

With limited resources, I had to look to convert the patients to private practice. With the patients needing little treatment, schemes like Denplan and Practice Plan were very attractive.

I took on the lease of an adjoining unit. This enabled me to add two more dental surgeries and a hygienist surgery that were solely for NHS patients.

By encouraging the education of patients, the staff were motivated to obtain further qualifications. Two of my staff went on to become dental hygienists. We even took on the role of training student dental nurses for their qualification. I trained newly qualified dentists, helping them adjust to working in a dental practice. Everyone was educated in the power of prevention.

When I had to step away from dentistry I know that the new owners did not include patient education in their plans.

I know that politicians want to ensure children are taught toothbrushing in schools. It should be the parents who are responsible for ensuring their children clean their teeth properly. They need the education.

If the focus changed from treatment of patients to their education, all dentistry would be more successful. I know that the children that attended my practice will have grown up knowing how to look after their teeth and mouth. They even have the skills to ensure their own children will know how to look after their own dental health.

I hope this will stimulate a conversation on why there isn't more emphasis put on the education of patients.

T. C. Dickerson, England, UK

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