Please note that all letters must be typed. Priority will be given to those that are less than 500 words long. All authors must sign the letter, which may be shortened or edited for reasons of space or clarity. All letters received are acknowledged.

Technician training

Sir, — I have to take issue with you over your editorial 'DARG report' in which you state 'as a profession we are very good at training team members in basic science and clinical skills'. What about dental technicians? You seem to have forgotten perhaps the most important team members of all. The dental technicians have been marginalised, their professional skills and craftsmanship debased and the industry virtually destroyed. They are like the Incas — a forgotten species.

The dental profession has been notoriously bad at training dental technicians at clinical skills, indeed it is totally opposed to it, as the BDA response to the DARG Report clearly shows. The situation can only become worse as the dental undergraduate today learns little or no dental technology and certainly has no experience in this vital part of dentistry.

Perhaps the BDA (and the *BDJ*) could play a part in encouraging the formation of a British Association of Dental Technicians. A professional representative body for dental technicians is long overdue and could do much to revitalise the industry.

N J Knott
Chippenham

Child care and oral health

Sir — I was lucky enough to be present at the conference on 'The Dental Care of the Disadvantaged Child' (guest leader *BDJ* 1999; **186:** 102). The speakers clearly cared deeply about the well-being of children. I am concerned however about the practicality of the two 'long-term answers' set out by Naylor and Winter.

'Nation-wide fluoridation of the domestic water supplies' would be effective in reducing dental caries across the social scale[1] — but its future is uncertain as we await the publication of the Government's white paper on public health. The omens are not encouraging, as recent correspondence in *The Pharmaceutical Journal*[2] shows that even fellow health professionals have serious doubts about it.

'Education of parents and children' will be effective only if supported by the creation of healthy environments for children to grow up in. If fluoridation is not available to get into 'the nooks and crannies of society' then oral health promoters must do this themselves, or train others who are appropriately placed to do so. This philosophy underpins the HEA's new oral health and nutrition training programme for child carers, which will be launched later this year. Delivered through the Community Dental Service, it will enable childcare staff working in nurseries and local authority family centres, in deprived areas, to promote the oral health of young children. This approach is backed by our research, which showed that the parents interviewed turned to child carers, rather than health professionals, for credible and non-judgemental advice, because it was perceived to be grounded in experience.[3]

C Stillman-Lowe
London

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1 Kay E J, Locker D. Effectiveness of Oral Health Promotion: a review. London: HEA, 1997.
2 Clein P M. A matter of concern. *The Pharmaceutical Journal* 1999; **262:** 159.
3 Kay Scott Associates. Oral Health Promotion in Pre-schools: report on qualitative needs ssessment. 1998.

The dental care of children

Sir, — Well done Naylor and Winter for their guest leader (*BDJ* 1998; **186:** 102)!

For the past twenty-five years, successive governments have maintained a policy to concentrate the provision of dental care for children on the family dental services. This policy has been disastrous for the dental care of children and dentists alike.

Despite falling dental caries rates, the overall quality of dental care received by the child population has been deteriorating until it has reached the present unacceptable levels. Locally, despite high registration rates, 70% of the caries-affected twelve-year-old children were recently found to have one or more untreated decayed permanent teeth. A similar picture may be found across the United Kingdom.

Little thanks and shrinking income margins have been the rewards for general dental practitioners. These issues have been highlighted by the debacle over the recent award by the Pay Review Body. Let me stress that it is the system which is at fault, not the individuals who are trying to make it work.

The problems appear to have started shortly after the demise of the school dental service. These continued with the limitations imposed by HC(89)2 on the mandate of the community dental service. The Chief Dental Officer needs to take a courageous decision (shades of Sir Humphrey) and institute a full review leading to fundamental reform of the system.

Personal dental services are not the answer — that is just rearranging the lifeboats on the Titanic as she sinks beneath the waves.

S Fallon
Messingham

Cast appeal

Sir, — I recently presented a poster at the IADR annual meeting in Vancouver that indicated a straight line correlation between occlusal and cervical (abfraction) wear.[1] This was a pilot study that used sequential casts of one individual over a period of four years. The loss of contour at occlusal and cervical sites on three teeth was reported using digital and visualisation techniques developed at the University of Minnesota School of Dentistry.

The next step in this fascinating study is to expand our database by including a greater number of subjects. I write to ask if any members of the British Dental Association have sequential casts of teeth with abfractions, taken over a similar period of time. If these are available, it would be helpful if they could be sent to Professor Trevor Burke, Glasgow Dental School, 378 Sauchiehall Street, Glasgow, G2 3JZ. He will have the casts duplicated and sent to me. The original casts will be returned to the sender, and all personal data will be kept confidential.

M R Pintado
Glasgow

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Radiograph selection

Sir, — We were concerned and rather bemused by the letter 'Orthopantomographic detection of a metallic foreign body in the neck' (*BDJ* 1998; **185:** 501) by Okuda *et al.* The authors concluded their case study by stating that it represented 'another benefit of routine orthopantomographic assessment' and confirmed 'the necessity for appropriate radiographic screening'.

The case does not justify either of these conclusions as the choice of panoramic radiography was quite inappropriate. The demonstration of the foreign body by this type of tomographic image was, by its nature, fortuitous rather than an indicator for the technique.

Radiographs should be chosen to suit the

particular clinical situation. In this case an appropriate examination of the neck would have been a lateral and postero-anterior view of that region. These views appear not to have been carried out.

It has been demonstrated on many occasions that 'routine' panoramic screening is unproductive, leads to unnecessary x-ray exposure and, presumably, unjustified extra costs to health service providers and/or patients.

The lesson to learn from this case is that it is better to use appropriate radiographs rather than the usual 'knee-jerk' reaction of taking a panoramic radiograph in every conceivable clinical situation.

V B Rushton
K Horner
Manchester

The authors respond: *We chose the orthopantomogram because the patient suffered from injuries in the eye, lip, tooth and neck. An orthopantomograph was necessary in order to detect the metallic foreign body and tooth fragment produced by possible migration into the soft tissue. The postero-antrior projection radiograph brought to us failed to show any retained objection at the neck wound. However, an orthopantomograph taken at our hospital produced evidence of the neck involvement. This would be due to the direction of migration of the foreign body. Orthopantomographs give us a lot of information on the dental and maxillofacial area and may produce some unexpected findings.[1] They may be useful in analysing the positional relationship between the tooth and the foreign body when there are traumatic injuries to the soft tissues and tooth with its defect. We agree that it is important that radiographs should be chosen to suit the clinical situation.*

Reference

1 *McKeown H F, Sandler P J. A nasal foreign body detected on routine orthodontic radiographs.* Br Dent J *1998;* ***185:*** *390-391.*

Increase in retention fees

Sir, — I felt I should write a small protest at the proposed increase by the GDC in annual retention fees for the coming year. I read Dame Margaret Seward's short statement, to the effect that nobody likes an increase (particularly one of 50% in one go!) but that they felt it was necessary to cover increased legal and publication costs.

While I am not totally *au fait* with the working of the GDC, it seems to be going down the road of hospital trusts and administrations, whereby more money is spent regulating and legislating against all kinds of subsidiary aspects to their real duties. In their case, looking after patients not administrators and, with regard to the GDC, maintaining standards and regulating dentists. Lawyers will always be willing to take more and more from you, but is it wise to keep hiring them for every small enquiry you may have? Or for that matter to publish everything you can, sending out large amounts of mail/paper throughout the year with consequent postage costs on top. The 'looking after' and 'advisory' part to the dentist should and does come from the BDA and need not be repeated by the GDC. At least with the BDA, whose fees also seem to rise, membership is not compulsory.

In the last years we have seen a rise by the GDC of a whole 50% in 1996, and again another 50% rise is proposed only three years later. Is it reasonable for any organisation to raise its subscriptions over 100% in five years (from £60 to £135), especially where we cannot by law vote with our feet as it were? The purpose of the GDC, I would suggest, is purely a legal registration, and for that fees should be minimal. Any sidelines can be paid for by individuals as they choose and should not be forced upon us by law.

I am also aware that for an increasing number of part-timers, such as myself, doing only a few sessions weekly, such a rise is a hardship as the increase is proportionately a considerable percentage of salary. Can I suggest that the council considers using a sliding scale in future — similar to the defence societies whereby you pay less if you earn less? Or perhaps the council would consider the fee as a fixed percentage of gross salary earned?

R Kitchen
Bristol

Sedation drug use

Sir, — The correspondence by P D Challen (*BDJ* 1999; **186:** 368) raises some rather alarming opinions on the provision of intravenous sedation in primary dental care. The advocacy of more than one drug for intravenous dental sedation must not be condoned. It is in direct conflict with the GDC guidelines on conscious sedation and contradicts all current teaching practices.

Dr Challen states that midazolam is not inherently safe. This is a point that must be contested. Since its introduction into the UK a decade and a half ago there have been no fatalities in primary dental care using intravenous midazolam sedation. When administered to carefully selected adult patients, using the correct method of a slow, intravenous titration, with the final dose measured against the patient's response, midazolam is a drug with a very good margin of safety. The delay in onset of sedation is not a clinical problem when the titration is performed in the accepted way. Although midazolam is not the 'ideal' agent, by virtue of the fact that no analgesia is produced, it stands alone as the current agent of choice for intravenous dental sedation. Research is continuing into potential alternatives such as propofol, but at present intravenous dental sedation must be single drug only, with midazolam offering the most ideal profile of the currently available benzodiazepines.

I am considerably concerned about the advocacy of multiple drug intravenous sedation in children as young as four. When sedation is indicated in a young child the most generally accepted method is that of nitrous oxide inhalational sedation. On the extremely rare occasions when an intravenous sedative technique is indicated for a child, then a specialist unit in a hospital environment is the only place this should be carried out.

The use of multi-drug techniques in a dental practice environment must be totally condemned, whether a dentist or an anaesthetist is responsible for administering the sedation. Performing such methods in primary dental care, especially in children, may not only invite a charge of serious professional misconduct from the GDC but will do nothing to protect the public from a potentially dangerous practice.

Of course, all dentists practising intravenous sedation must have undergone an approved postgraduate training which involves both practical and theoretical elements whilst under appropriate hands-on clinical supervision.

S M Ellis
Cambridge

Sedation is not the only answer

Sir, — The recent letter by Girdler (*BDJ* 1999; **186:** 158) emphasises sedation as a safe alternative to general anaesthesia for anxiety control. Although dental anxiety may be contained by the use of pharmacological adjuncts such as intravenous sedation, considering only the use of pharmacology in the management of dental anxiety ignores the proven success of non-pharmacological treatment methods.[1,2] Intravenous sedation, although beneficial for difficult surgical procedures, and for patients with medical and learning difficulties, has significant short-comings. Intravenous sedation is less successful for the patient who is needle phobic or who suffers from mistrust and fears losing control. It plays no role in helping the patient develop the skills to manage their own anxiety and consequently places a patient in a vicious cycle of drug dependency for regular dental

care.[3] This results in an ever growing burden of dental care that will be accompanied by ever spiralling costs. An alternative approach is to teach a patient coping skills, such as relaxation breathing and muscle relaxation; or addressing the needle phobia through the use of a structured needle desensitisation program. A myriad of additional behavioural and cognitive approaches are also available which allow the patient to successfully cope with dental treatment.[4]

This approach may be more time consuming initially and may occasionally require the use of relative analgesia as a pharmacological adjunct, which to be highly successful should be combined with behavioural techniques. However, it does eliminate long term dependency by teaching patients how to cope with and manage their own anxiety. Certainly considering only solutions to the complex problem of dental anxiety/fear and phobia ignores the potential of safer, long term solutions to this problem.

Dentists may find it beneficial to add non-pharmacological techniques to their complement of skills for effectively treating fearful patients.

J Levitt
P McGoldrick
D Evans
A Mason
Dundee

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3 Levitt J, McGoldrick P Mason A, Evans D. Psychology or pharmacology in the treatment of dental phobia. *J Dent Res* 1998; **77:** 828 Abs 1572
4 Milgrom P, Weinstein P, Getz T. Treating Fearful Dental Patients - A Patient Management Handbook. University of Washington: Seattle, 1995

The DPB reference service and the GDP

Sir, — Of the examinations carried out by the Dental Practice Board's reference service only a very small proportion give cause for concern (Annual Report of the DPB). This confirms the honesty and effectiveness of the vast majority of the profession. However, questions that need to be considered are:-

1 Is the money spent by the reference service used efficiently. This was £4.2 million last year.
2 Is the system unnecessarily damaging to the public's perception of the profession's honesty?

The answers to these questions are obvious if one considers the situation where a dentist taking his turn on an emergency rota sees a patient on one occasion only for emergency treatment. Treatment is the issue of a prescription, dressing or something similar. This is the sort of case that seems to be a target for the reference service at present. What are the patients to think when they are told that they are to be seen by a government dentist and that they must have no treatment until this is done? What can the examining dentist do on these occasions except ask 'Did Mr X see you on the date claimed?' and to note the positive answer. A large sum of money will have been spent on setting up the examinations while undermining the patient's confidence in the profession to the maximum degree. A letter to the patient could well obtain the same information. If this were to be carefully worded it could be disguised as market research so that it did not look like an honesty check on the dentist. If a prepaid envelope were to be enclosed for the reply then the response rate could well exceed that obtained by asking patients to attend an examination and the cost to the reference service would be minimal.

Similarly, when completed orthodontic cases are reviewed, is it really necessary to involve the patient in all these cases when the reference service has available the patients' record cards, pre- and post- treatment models and radiographs? Surely only in those cases where the dentist does not make these records available, or where they show problems, should the involvement of the patient and the expense of an RDO examination be considered.

I hope that this letter will provoke the development of better ideas on the methods of monitoring our work that will be both more cost effective and less damaging to the image of the individuals making up our profession.

P D Brun
Folkestone

CPD for deaf users

Sir, — I was delighted to read of your new initiative for continuing professional development through the *BDJ* and CAL programmes.

For the last twenty years I have been unilaterally deaf, but following recent neurosurgery I am now totally deaf. My principals and patients have been wonderfully supportive, and on a one-to-one basis I can cope, but large numbers and darkened slide shows would tax the most proficient lip-reader. This saddens me, as I have always been active in pursuing continuing education, but I read the journals avidly and wrestle with our computer on CAL programmes.

Obviously CPD will create new challenges, but I owe it to my patients and to myself to explore every option, and your new initiative is an excellent opportunity for those, like myself who find attending post-graduate courses difficult.

J Graham
Torquay

Minority ethnic groups in health care professions

Sir — The following is a statement from minority ethnic dental professional groups following the publication of the report of the inquiry chaired by Sir William Macpherson into The Death of Stephen Lawrence.

The report of the Macpherson inquiry shocked the nation and challenged every section of British society to review the issues if institutional racism in order to build a community life, which is based on equity and justice. The inquiry has not only exposed shortcomings in our society, but also provided opportunities for change.

The lessons of the tragic death of Stephen Lawrence should not only impact on the workings of the Metropolitan Police force but also on the NHS as one of the largest employers of the minority ethnic community. The health care professions in the United Kingdom constitute some of the most desirable vocations for minority ethnic groups, of which dentistry is probably one of the most attractive. In the last decade undergraduate dental schools have seen their intake change dramatically as an increasing number of minority ethnic individuals apply and are selected for entry.

Now is the time not for rhetoric and accusations, but reconstruction and a commitment to build a positive and inclusive dental health care profession. In preparation for the new millennium our organisations are committed to working together and with all sections of the dental profession in a constructive and sensitive manner. It is our hope and vision to build upon the great achievements of the NHS to which so many have contributed.

This letter is to underline the minority ethnic health care community's commitment to help to develop a positive and inclusive dental profession.

R Bedi
National Centre for Transcultural Oral Health
J Patel
Muslim Doctors and Dentists Association
S Najeti
Anglo-Asian Odontological Group
London