Send your letters to the Editor, British Dental Journal, 64 Wimpole Street, London W1G 8YS. E-mail bdj@bda-dentistry.org.uk
Priority will be given to letters less than 500 words long. Authors must sign the letter, which may be edited for reasons of space.

GDC Annual Retention Fee — a legal point of view

Sir, — The proposed increase in the ARF has generated a predictably large volume of correspondence in the dental press. Various aspects of this subject were debated at the annual conference in Belfast and Elinor Parker's report (*BDJ* 192, 719-722) records that a system may be considered whereby costs may be recovered from dentists 'found to be at fault' by the GDC.

Those currently reviewing the GDC's Fitness to Practise procedures will need to give very careful consideration to any proposal to recover such costs and the potential implications.

Firstly it will be necessary to carefully consider what is meant by 'at fault'. Will a dentist who is found to have a health issue affecting his ability to practise be expected to pay the legal costs of the Health Committee dealing with the matter? I suspect not.

Will a dentist who is found to be guilty of serious professional misconduct (or perhaps 'misconduct' in the future) but does not have a sanction imposed upon their registration by the Council be 'at fault'?

Will a dentist who is found to be guilty of 'poor performance' (definition yet to be decided but proposal under current review) be 'at fault'?

It should also be recognised that any attempt to introduce what lawyers refer to as 'costs orders' into the GDC's processes is likely to achieve little beyond redistributing dentists' funds and will be fraught with difficulties.

For example, if the GDC becomes empowered to order that a practitioner whose name is erased from the Register has to pay the costs of the GDC investigation, presumably those costs will fall to be paid by that practitioner's defence body.

The consequence will be, ultimately, that defence body premiums are increased. They are of course paid by the same practitioners who pay the ARF.

Equally, if the process is changed to allow the GDC to recover costs from those found to be at fault, then presumably the same system must allow the defence bodies, or individual practitioners, to recover their legal costs from the GDC if they are subject to an investigation and then found not to be at fault. This would impact upon the ARF.

Finally, any system which means that the GDC, albeit indirectly, has a financial interest in finding a practitioner 'at fault' at the end of their inquiry (because the GDC would be able to recover their costs) would appear to be, *prima facie*, unfair and thus potentially in breach of Human Rights legislation.

C. D. N. Morris
London

CDO report

Sir, — I have just read the CDO's full report sent to all dentists in the UK. Am I alone in thinking the Emperor/Empress has no clothes?

C. Debenham
London

Dentistry in the military

Sir, — Having spent several years practising dentistry in the armed forces, I always knew to instruct military aircrew that they were grounded for 24 hours following a dental local anaesthetic. Now in civilian life, married to an airline pilot and having quite a few members of airline staff as patients, I wondered whether the grounding rule was just a military regulation or applied to civilian aircrew as well. The Civil Aviation Authority (CAA) refers pilots to the 'Joint Aviation Regulations, Flight Crew Licensing, Medical Section' (JAR-FCL 3 Med) book. This states that all procedures requiring a local or regional anaesthetic shall disqualify a pilot from flying for at least 12 hours. It also states that they should not exercise the privileges of their license when they have a medical condition, or are taking prescription or non-prescription medication, which can have an adverse effect on their ability to perform their duties safely.

Individual airlines may make their own interpretations of these regulations. One 'Flight Operations Manual' I have seen states:

- Pilots are grounded for 24 hours after a dental local anaesthetic.
- Grounded for 3 days following tooth extraction.
- Must not fly whilst they have dental sutures in place.
- Must not fly whilst taking antibiotics.

This all begs the question why:

- Modern local anaesthetics rarely have side effects. The grounding rule appears to be because some particularly apprehensive patients may have an extreme stress reaction to the dental procedure rather that the anaesthetic itself. Recently filled teeth may also show signs of barodontalgia, pain due to atmospheric pressure changes.
- Grounding after an extraction would seem to be obvious with the possibility of air emphysema at the extraction site. However, it never occurred to me that wind instrument players could potentially have the same problem. Think of those orthodontic extractions that had a flute lesson the next day!!
- Grounding during antibiotic medication relates more to the fact that the pilot has a condition requiring the antibiotics rather than the pharmacology of the medication itself. However, if the dental condition is such that strong painkillers are required, then the side effects of the painkillers could be more of a reason for grounding.

Barodontalgia may cause significant pain for aircrew, and can occur at altitudes as little as 2000m. Toothache on ascent is usually true barodontalgia. It occurs under a recently filled tooth or teeth with deep fillings. This pain is usually relieved on descent. Pain only on descent is more likely to arise from the maxillary sinuses and is generally specific to the upper posterior teeth. Divers can also experience similar effects with teeth and sinuses.

Interestingly, are readers aware that upper dentures are less retentive at altitude? One wonders whether submariners have more retentive dentures.

There is no requirement for pilots to have a dental fitness certificate in order to pass their annual medical test, nor is a dental check included in the medical fitness test. However, in order to reduce the effects of potential barodontalgia, and airline crew rostering nightmares when pilots find themselves unfit for duty

following dental treatment it may be prudent for us, as dentists, to suggest to pilot patients that they consult their employer's guidelines regarding fitness to fly following dental procedures before we agree on a treatment plan.

Aircrew generally should be encouraged to maintain a high level of dental fitness. Due to the nature of their job with missed meals and time zone changes, airline staff are more tempted towards high energy snacking and sugar ladened drinks. It is horrifying how many sweets and chocolate bars end up in crew meals. Good dental health reduces the need for dental treatment, which has additional implications if airline staff have to seek treatment in countries where AIDS and hepatitis are endemic.

Note, cabin crew are not covered by the same regulations as flight crew. Each individual airline has its own regulations regarding cabin crew. My thanks to the Aeromedical Advisors, at the CAA for their help.

H. K. Ellingham
Norwich

Longevity of restorations

Sir, – With reference to Professor Burke's research on the longevity of restorations (*BDJ* 2002; 192: 699-702) and mindful of not starting a stream of correspondence on this, 'I've got the oldest amalgam on record'. May I be allowed to recount an experience with a patient recently.

On examination it was noted that the patient had lost a buccal amalgam on the lower right second premolar. Unremarkable you may think, but as it was the patient's only restoration, quite an event. The patient was able to recall when the restoration was placed: in 1941 whilst serving in the army, in a caravan in the Western Desert by an RAF Dental Officer. I have the honour to be, Sir, your obedient servant.

J. H. Harker
Hove

What is a dental emergency?

Sir, – What is a dental emergency? Or what is not? Having recently finished a 5-hour evening session at Dentaline, an out-of-hours hospital based clinic that operates in Kent I am wondering whether the patient's work-commitments and holiday arrangements come into the equation?

Take the following scenario. An engineer who has an appointment next week for treatment on two broken teeth with his private dentist.

It is Saturday night and his company who have contracts at an airfield in Turkey have asked him to change his plans at short notice to replace a colleague who has broken his leg – a medical emergency. The patient now classes his dental treatment as an emergency as he cannot keep his dental appointment and go to Turkey. He is not in severe pain but knows his teeth need attention.

When I ask him why he did not refuse the job offer he tells me he does not want to be vulgar and mention actual sums of money but I would understand if he told me how much he earned. If he earns so much why doesn't he get the treatment done privately? 'Have you ever tried to get an appointment with a private dentist on a Saturday night?' he laughs.

They have dentists in Turkey surely? Yes, but it would be inconvenient to find one that would fit in with one's work schedule. So, is this chap to be classed as a dental emergency?

E. T. Taylor
Maidstone

Problems in dentistry

Sir, – I find your Opinion article and all the letters in the recent *BDJ* (*BDJ* 2002; 192: 667-671), as well as the research paper 'Influence of the method of funding on the age of failed restorations in general dental practice in the UK' in the same journal all reflect the current problems in UK dental practice. These have been caused by the profession's inability to effectively negotiate with successive governments for the benefit of our patients and the profession.

The OFT investigation should be an ideal time to show that, far from the private fees charged being excessive, NHS fees are pathetically low and not compatible with even third world dentistry. Why have we found ourselves in this state? We need to accept a few home truths about the profession and the way we are currently forced to practise dentistry. There is no need to lay blame at the door of any one individual because everybody has been trying to do what he or she thought best. We must however accept collective blame, as we are the guardians of the care we offer to our patients and it was our responsibility not to allow the situation to deteriorate to the current levels.

Further tinkering with the system and accepting that 'Options for Change' is really going to fundamentally change anything, apart from stirring the already muddy waters, is laughable. At the end of the day there is not, never has been and never will be enough money in the NHS system to cope with treatment demand.

As I have said, no one person is to blame but how can we possibly accept any credit for a system that currently pays £71.10 for molar endodontics, £6.65 for a clinical examination and report or £11.90 for a single extraction? Even the GDC must share some of the blame. Paragraph 3.2 of their publication 'Maintaining Standards' says, 'A patient is entitled to expect that a dentist will provide a high standard of care. The Council takes a serious view of any neglect of a dentist's professional responsibilities to patients for their care and treatment'. Further, paragraph 2.3 of the same publication states, 'Any act or omission by a dentist in connection with dental practice which is liable to mislead the public may lead to a charge of serious professional misconduct.'

I would contend that the dental members of the GDC should consider reporting themselves, for serious professional misconduct, by their omission to point out to the general public that NHS dentistry can never be of a high standard given the level of fees highlighted above. What is the answer?

Firstly, there can be no sweeping statements and no easy or quick fix. The way dentists practice dentistry is probably unique in every practice up and down the land. What is right for one is not necessarily right for the next. I think the time is right for a fundamental, hard-hitting, no holds barred, review of the past, present and future. Our previous negotiators have served us well and done a good job in the circumstances but it is time for them to step aside, their heads held high. They do however need to make themselves available for advice, in order that some of the past pit-falls can be avoided.

The BDA, as the largest professional organisation, needs to lead this fundamental review with new negotiators but I would ask them to consider the following ideas.

- Launch a sustained PR campaign to gain public support for the measures to be implemented.
- Every practitioner should be actively and forcefully encouraged to leave the NHS.

This needs to be done at a pace that he/she is comfortable with and is compatible with their circumstances. This may be by initially taking out adults only, or adults and exempt, or the 'whole lot'. This may also be via a capitation type scheme. Only by reducing the number of dentists within the system will the government of the day be forced to come to the profession for a solution.

There would be no need to massively increase fees. These could rise from between 50-100% of current NHS fees dependant on individual circumstances. Current adult patients, who already pay

80% of the fees would hardly notice the difference, especially if each practice took the time to discuss them.

For those that argue that we are duty bound to the NHS or that as a profession we need to support the NHS, I would say that the only way we can eventually offer a system that is to be envied is by enduring some pain at the start. As a profession we must rise above the political short-term solutions and look to the long term in order to ensure we best serve all our patients. There will never be sufficient funding to provide a full and high quality NHS for all.

- Keep NHS fee rises in check at a low level. Dentists are not perceived as poor. They have made the system work by subsidising the NHS with private fees or by playing the system. Older practitioners probably subsidise the current fees from relatively higher fees in the past, that have allowed them to purchase their own homes, and possibly their practice (something younger practitioners cannot do). If we simply asked for a massive increase in fees some practitioners would simply continue to work as they do and put the extra in their pockets.
- At a suitable time, stop all practitioners from mixing NHS and private fees. We have been shooting ourselves in the foot by subsidising the NHS with private fees. All we have done is continued to prop the system up. What other profession or organisation would accept less than cost effective fees from one organisation (the NHS) and subsidise them from another organisation (our private patients)? The timing of this would be critical and may be linked to the following point.
- The launch of a properly funded NHS system with highly paid practitioners. Once sufficient patients have been forced from the NHS by a lack of dentists we can launch a new NHS. This new NHS will have limited scope, will apply to a limited number of patients and will concentrate on prevention rather than cure. It will have highly paid salaried professionals who will have some targets so that under-prescription is not encouraged. The pay will be sufficient to attract good quality practitioners and there should even be competition to be allowed to be an NHS practitioner. The system will be fully supported by the dental hospitals and specialists. Only by driving out the vast majority of patients, can sufficient money be left to properly fund the NHS for those that cannot afford the private system.
- The private system. Here there will be different levels of service that will be driven by local needs and requirements but essentially the local practitioners will be in charge of setting fees for the level of service that they will provide.

As I have said there is no easy solution, but I hope to stimulate some discussion to find a way out of the impasse.

S. M. Gallier
London

Preparing veneer crowns

Sir, – I write to commend the authors of the excellent article on the preparations for full veneer crowns (*BDJ* 2002; 192: 561-571). It was an extremely useful and practical article. There was however a small aspect I failed to understand. In the text under Figure 7 it states that it is important that the radius of rotation intersects the opposing axial wall to prevent tensile forces fracturing the cement lute.

As can be seen in the diagram there would have to be movement in the crown, following fracture of the cement lute, before this comes into play. I appreciate that the diagram is designed to be illustrative but would there not be some movement before intersection of the opposing axial wall increases resistance?

M. Wanless
Preston

Surgical emphysema following routine preparation

Sir, – I recently experienced surgical emphysema following a routine crown preparation on my lower right 4.

This produced a marked swelling of my right cheek and I 'crackled' to the touch from my temple to my clavicle, and from the mid line to the angle of my mandible. This happily all returned to normal within 72 hours.

This tooth has not been root treated and my teeth are brushed and flossed within an inch of their lives daily. I have 2 mm of loss of attachment buccally through toothbrush abrasion and the buccal plate is thin in this region.

The procedure was carried out using a mental block and 'Septanest' (articaine with adrenaline). I had taken 600 mg of clindamycin as antibiotic cover 1 hour before. I would be most interested to learn whether others have any experience of this, and to hear opinion on the possible causes.

D. J. Chapman
New Malden