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.

Tooth whitening

Sir,- I am very aware of the current problems associated with peroxide-related whitening of teeth. There is considerable market pressure to supply this treatment. However, I am appalled that the dental profession, including defence societies, has not emphatically stated that any dentist providing peroxide bleaching, especially with regard to the high concentrations associated with such products involved in office techniques, is in contravention of European Law and, therefore, UK law. We may strive to use this clinical technique where appropriate, however, in the meantime, I feel that the arrogance of some of our profession in contravening British and European Law, can only be perceived as unprofessional, until the product has obtained the adequate licence. Until then, please correct me if I am wrong, these products are illegal, and supply of them carries penalty of fine and prison sentence. Surely this is not the public image that we are trying to achieve for the British dental profession.

L. Mullarkey
by e-mail

The Editor comments: *This letter is timely as the current legal position has recently been clarified by the BDJ's legal advisor, who has published a short paper in this issue on pages 375-376.*

Assessing attitudes in dental education

Sir, I was most interested to read the article by Brown, Manogue and Rohlin over the need to assess attitudes in dental education (*BDJ* 2002;193:703-707). I agree with their cautious 'yes' as a conclusion and with their description of the relationship between attitudes and behaviour. Unfortunately they then go on to confuse these two aspects and in doing so set unclear and therefore unattainable aims for the education of dental students. I wholeheartedly agree that the development of professional behaviour should be one of the aims of the undergraduate programme, not least of all because the consequences of unprofessional behaviour are adverse for the patient, the profession and for the dentist him/herself. Therefore we must be clear about our aims. By stating that the correlation between attitude and behaviour is not always high and then going on to state that unprofessional behaviour could be described as a product of attitude, seems to me to be confusing, if not contradictory.

In their arguments for focusing on attitudes they cite a list of activities (e.g. advocating extractions and adhering to a dress code) which are thus by definition not attitudes. Some of the questions posed in this list are of a moral or ethical nature, but their answers lie in the appropriate behaviour being exhibited and a decision being made over what this behaviour entails. They rightly point out that inferring attitudes from behaviours is complex and then go on to suggest the use of direct observation as a method of assessing attitude. The other methods have the same shortcomings; they assess the level of knowledge of expected behaviour.

Louise Arnold in her excellent article[1], suggests that assessment of professionalism should focus on professionalism in and of itself. The recent Dutch report on the assessment of professional behaviour by the project group Consilium Abeundi[2], also suggests that efforts are focused on the observable behaviour.

At the end of the day the dentist is assessed by patients and his/her colleagues on his/her professional behaviour. The GDC disciplinary committee examines unprofessional behaviour/conduct (not attitude).

It is therefore reasonable to include the development of professional behaviour within the undergraduate curriculum and thus assess the professional behaviour of dental students. Surely as educators of dental students we have the responsibility to clearly demonstrate and assess the level of professional behaviour expected from them on qualification, and the responsibility to give them the knowledge that the exhibition of professional behaviour is expected throughout their practising lifetime.

Behaviour is observable, assessable and therefore clearer to teach. The fact that this may also have a desirable effect on the students' attitude can only be a bonus.

S. Shaw and O. Hokwerda
Groningen, The Netherlands

1. Arnold L. Assessing Professional Behaviour: Yesterday, Today, and Tomorrow *Acad. Med.* 2002; **77:** 502-515.
2. Eindrapport van het Projectteam Consilium Abeundi ingesteld door het DMW (VSNU) Utrecht, juli 2002.

The authors of the article reply:

As we said in our article, views about attitudes do differ. The view that Drs Shaw and Hokwerda take is behavioural whereas our view is closer to an approach based on cognitive and social psychology. However, the differences between our viewpoints are not as great as might first appear.

We agree that professional behaviour is important but to merely focus upon professional behaviour is to avoid the central question: from whence does this professional behaviour come? If it is not random or merely a mechanical response to environmental stimuli, then it must be stored in the human memory along with knowledge, understanding and skills. If it is stored, then we suggest that attitudes are a useful way of labelling this 'predisposition to act'. And, if professional behaviour is stored, how is it best learnt and retrieved, assessed and used? This was the basis of our article and we point out that attitudes may be worked on directly or indirectly by changing knowledge, understanding, skills and behaviour itself (see Figure 1 in our paper).

We do not confuse attitudes and behaviours but we do point to the challenges of inferring attitudes from behaviours and the risks of assuming an expressed professional attitude as a guarantee of professional behaviour. People often say one thing and do another.

The authors are right to point out that 'dress codes' and 'extractions' are behaviours not attitudes. They could also have pointed out that the GDC list of attitudinal objectives are manifested in behaviours of differing types and degrees of complexity (our Table 1). The point we wanted to make is dentists do have different attitudes towards these behaviours. We also reminded our readers that attitudes are, in part, historically and culturally determined. Hence we are wary about the notion of measuring attitudes as if they were lengths on a ruler. Assessing attitudes is more a matter of judgement than measurement, although the judgements may be subsequently mapped on to numbers.

We agree that all behaviour is potentially *observable but we are less confident that it is always measurable precisely. There are technical difficulties about observing behaviour - how often, by whom, when, how many different contexts and criteria are all relevant issues. In addition, there is a temptation to take 'easy' observations and measurements rather than tackle the important and challenging issues.*

We think that the effects of education on students' attitudes should be more than a bonus: it should be a primary focus. Unless professional attitudes and abilities are developed along with other competencies then professional behaviours may not be sustained in later life.

G. Brown, Nottingham
M. Manogue, Leeds
M. Rohlin, Malmo, Sweden

No smoke without ire

Sir,- I am disappointed with the cover of the *BDJ* (Vol 194 No. 4). At first glance it appears to be an image of someone smoking. It is only with closer scrutiny that you realise that it is an artistic image. Indeed, a small survey of staff in our department agreed that it appeared to be someone smoking.

However with the knowledge that smoking increases the risk of oral carcinoma, and is detrimental to ones health generally, is this the sort of image that the BDA/*BDJ* wants to be associated with? I think not. Indeed we have a duty to actively encourage people to stop smoking. This is not helped by the publication of such images.

A. Curtis
Aylesbury

The Editor replies: *This letter took us all by surprise at the editorial offices, and I can confirm the BDJ is still committed to its anti-smoking policy. Obviously we will try to be more careful of the potential interpretation of future covers.*

Denture cleanliness?

Sir,- A patient attended the Department of Prosthodontics in Goa, India, requesting a complete set of dentures on an emergency basis. His complaint was that his dentures were fractured and he was suffering considerable embarrassment due to loss of anterior teeth.

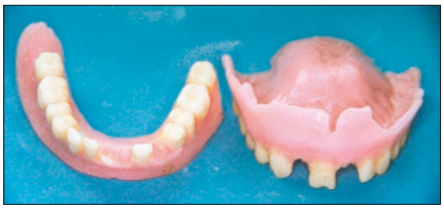
On careful questioning, his history was astonishing. His pet Pomeranian dog allegedly ate up part of the denture. He said that he used to feed his pet dog regularly with meat. On the ill-fated day there was no meat for the dog but he himself had meat for the afternoon meal.

Following lunch he just rinsed his mouth and had neither brushed nor cleaned the denture. Then, as was his usual practice, he removed his dentures, kept them under his pillow and went to sleep. His pet dog was also in the same room.

The next thing he remembers is hearing a cracking. He woke up and realized that the dog was chewing up his dentures. He then quickly rescued the denture (see below) and rushed his pet dog to the veterinarian, as the dog had eaten part of the denture. The patient was highly embarrassed while narrating this story.

This report shows the need for proper denture hygiene. Also the need to feed pet dogs with their regular allocation. Hence, we in the dental profession should warn the patient of the possible consequence of unhygienic dentures. While it can be concluded that this is an extreme case, it nevertheless underscores the need for excellent denture hygiene.

A. Fernandes
Goa, India



Forgotten Fish

Sir,- In *The Times* (22.02.03) the columnist Jonathan Meades has an article, 'Ask your children who Graham Sutherland was...', in which he describes polling young people to find out if they had ever heard of this great British painter. None of them had, and I was reminded that when researching at the BDA library for my biography of Wilfred Fish, I asked several young dentists there if they had ever heard of Fish. None of them had.

Lawyers have access to their history through case law, which is full of names, and in medicine the history of the profession can be traced through many anatomical features and diseases which have eponymous names, e.g. Adam-Stokes, Addison, Willis, Boyle, Colles, Mantoux, Von Willebrand etc. come to mind. In dentistry we have Riggs, Tomes, Koplik, Briault, McCall, and of course Fish of the gingivectomy knife. There must be many more.

J. D. Manson
London