Letters to the Editor

Send your letters to the Editor,
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Priority will be given to letters less than 500 words long.
Authors must sign the letter, which may be edited for reasons of space.

MASS ACTION

Sir, the committee of the Hounslow & Twickenham Section of the BDA would like to express its concern at the BDA attitude to the forthcoming CQC registration. We are all dentists committed enough to the BDA to spend time and effort running an active Section. We have all been members of the profession for more years than we care to admit!

You were kind enough to attend our Section meeting in January 2009 as our guest speaker. On that occasion I had the honour as our Section Chairman to sit beside you at dinner and enjoyed our conversations on numerous matters, both dental, and non-dental. At the time the shadow of forthcoming HTM 01-05 compliance was beginning to darken the atmosphere. I clearly remember when we spoke I raised my concerns that the policy seemed to be based on a theoretical model that had no evidence to back it up, and that furthermore no additional benefit was apparent to patients if the 'best practice' recommendations were implemented in full.

I was amused by your answer when you stated that 'We dentists are generally too polite to make a fuss and just quietly get on with it.' My amusement was because I know this to be true! However, recent events have caused my sense of humour to start failing.

On top of the unproven and totally excessive regulations of the HTM 01-05 document, we are now about to have the CQC thrust upon us. I have yet to hear one member of our profession who feels this is a worthwhile idea. Again, no apparent benefit to patients can be seen, and again those of us who are trying to run ethical dental practices on behalf of our patients are going to have to pay for it.

I know this particular tune is not a new one. I have read acres of correspondence in other dental publications recently, and they all agree with what I state. Some of them have been quite sad with experienced and respected practitioners who had intended to keep working now throwing in the towel, or younger clinicians now contemplating emigration to Australia where they will re-gain their freedom. Rather ironic don't you think considering the founding history of that particular colony!

My reason for writing to you at the *BDJ* is that I have now reached the point after 26 years of membership, of resigning from the BDA. I have served as Chairman of my local section on three occasions and am also one of the earliest members of the BDA Good Practice Scheme.

As I am now paying over £500 a year for membership, plus payments for the CQC, I am seriously wondering just what representation we are getting? It appears that despite statements that the BDA are consulting with the DoH on the forthcoming CQC registration, no real resistance is being offered to a totally unnecessary quango. We are effectively being told, not asked, to pay the salaries of the individuals who are less qualified than those they are inspecting and then telling to comply with their regulations.

I already have to pay for my GDC annual renewal. This I agree is necessary regulation and is enough! I can choose whether or not to renew my BDA membership next year. With all of the recent increases in practice expenditure how many members of the BDA will decide that the money that they pay for BDA subscriptions should go towards CQC registration instead?

I cannot speak for the entire profession (but I guess I am for most of them), but I can speak for the managing committee of our BDA Section. This is a plea, through the pages of your esteemed and respected journal to the BDA to stand up and fight for your members. It is also a plea for fellow readers to join in and get some critical mass together. We do live in a democracy after all!

G. Painter
Chairman, Hounslow and Twickenham BDA Section
G. Hothi, P. Saunders, J. Durie, G. Ghani, M. Wardle, T. Wardle
Management committee

Peter Ward, Chief Executive BDA, responds:

Thank you for the opportunity to respond to Dr Painter's letter.

Colleagues in Hounslow and Twickenham are certainly not alone in their anxieties about Care Quality Commission (CQC) registration. I know from talking to practitioners across the country that the frustrations Dr Painter articulates about the registration of dental practices with CQC are felt by the vast majority of the profession. The BDA has been working hard to have dentists' concerns heard and addressed. John Milne, Chair of the General Dental Practice Committee, and Susie Sanderson, Chair of Executive Board, have personally made the case to the new Government for the situation to be looked at again. At the time of writing, their appeals appear to have gone unheeded.

The fight continues. It is important that the profession across England now demonstrates the strength and extent of feeling on this issue. That is why the BDA has launched a campaign to help practitioners do just that. In last weekend's edition of bdanews *members will have received a postcard that calls for a simplification of*

the CQC's functions, a reasonable fee and a delay while problems are addressed. I urge every dentist in England to fill in that postcard and send it to their Member of Parliament. We need the mass participation Dr Painter describes if we are to influence what happens next.

The BDA recognises the strength of feeling on this issue coming not just from Hounslow and Twickenham, but from sections and branches everywhere. That feeling now needs to be articulated in a consistent, coherent way. The postcard campaign we have launched provides the vehicle to achieve that and I urge everyone reading in England to join this campaign.

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SINE QUA NON

Sir, *bdanews* carried in September a 'forward' foreword by the Association's Chief Executive relating to the GDC's renewed interest in the title of 'Doctor'. It surprises me that not one of our cash starved universities has seized the opportunity to recognise the successful completion of two years' post-qualification vocational training by awarding a Doctorate in Dental Practice. This would provide recognition of the vocational training, provide a UK degree equivalent in name to international practice, legitimise the use of the 'courtesy title' and provide an additional income stream for the university. It is of course a *sine qua non* that there should be a 'grandfather clause' that those whose post-qualification experience precedes the introduction of vocational training should be eligible.

A. Green, Malaga

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SMALL VERTICAL CRACK

Sir, I would like to draw the readers' attention to an interesting case which I encountered on a patient recently. A fit and healthy 47-year-old lady presented to me as an emergency, complaining of a constant throbbing toothache with intermittent 'electric shocks' from the lower right side, which painkillers were not even '*touching*'. She began to experience these symptoms after biting on something and presented to the clinic after three days.

Upon clinical examination, the lower right seven, which had a small occlusal amalgam, was very tender to percussion and was positive to vitality testing. There was a small vertical crack running in the disto-lingual aspect of the tooth. A periapical radiograph was taken and is shown here (Fig. 1).

The lower right eight is impacted under the lower right seven, causing root resorption. There is loss of the lamina dura and therefore potential hindrance of the cushioning effects of the periodontal ligament. The lower right six is heavily restored, with radiolucencies associated with the distal root, and under the crown (likely radiolucent cement).

The prognosis of the lower right seven was poor, and after a full discussion with the patient it was decided that the best option was extraction.

As can be seen (Fig. 2), the vertical fracture has propogated down the length of the tooth. This may be attributed to the impacted eight and subsequent loss of the cushioning effect of the periodontal ligament.

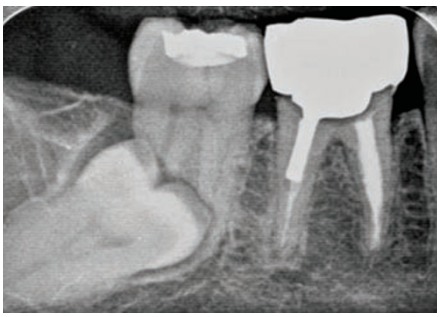

Fig. 1 Periapical radiograph

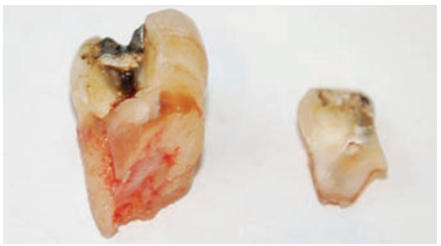

Fig. 2 Vertical fracture down the length of the tooth

P. Raval, J. Patel, London

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STRONG RESISTANCE

Sir, I write in response to Nigel Harradine's comments on a previous letter of mine (*BDJ* 2010; **209:** 439). While I am grateful for his comments, with all due respect I disagree with the content: the speciality of orthodontics is treating malocclusion as if it were a genetic disease. If, as he states, orthodontics has 'found very little good evidence to identify the environmental factors', then treatments provided must be genetically based or guesses.

The cumulated efforts of the British Orthodontic Society's (and its predecessor's) 'research, publications and presentations at meetings and conferences' over the course of 100 years have failed to elucidate the aetiology, pathology or cure of malocclusion. When common sense and the weight of published scientific evidence could so obviously prove an environmental cause, the fact that it has not suggests a strong resistance to opening this Pandora's Box. Calling for more research or review articles asks for an unethical delay, for material that could also be ignored. I believe that only a forum of active participation will deliver the truth.

We have been granted a legal monopoly over dental care on the condition that we act professionally and in the best interests of our patients. I feel that we are falling short of this. If repeating the GDC's debate of 1936 is not acceptable, would an independent review be?

BDA members are encouraged to comment on the BDA web forum.

M. Mew, by email

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A SUBJECTIVE OPINION

Sir, I see that Michael Mew feels we lack foundation to explain the aetiology of malocclusion (*BDJ* 2010; **209:** 439).

Nigel Harradine, Chairman of the British Orthodontic Society, has rightly refuted any conspiracy theory amongst specialist and academic orthodontists.

It remains to point out that 'malocclusion' is not a scientific term. It is a subjective opinion on how much a particular occlusion varies from the ideal. In fact the ideal is rare and variants are part of biological systems.

It is well recognised that heredity, development and environmental factors all play a part in a particular variant occlusion.

THERE IS NO ONE SIMPLISTIC CAUSE.

If Michael Mew has researched evidence for a new theory, it is very welcome. It is up to him to prove it, not for anyone else to disprove it.

T. Kolb, Cirencester

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A CERTAIN SYMPATHY

Sir, like Dr Burton in his letter *Diagnosis tosh* (*BDJ* 2010; **209:** 106), I too am appalled by the incorrect treatment and diagnosis provided by the two practitioners as well as the level of care in so much as allowing the patients to wait weeks before definitive pain relieving treatment could be provided.

However, I do hold a certain sympathy for the NHS practitioners concerned as they would expect a fee of say around £75 (three UDAs) for the molar endodontics which would of course include diagnosis, X-rays as well as a completed restoration, thorough examination and charting and possibly other treatment as well if it were needed.

I suspect the fee of £75 would certainly cover Dr Burton's expertise in diagnosis and X-rays and might even cover the final restoration if it were a smallish one, but it would nowhere near cover the fee for the endodontic treatment.

I have been running a predominantly NHS practice for over 33 years and certainly do molar endodontics, and see my patients within 24 hours if they are in acute pain, but I am more in fear of litigation nowadays if the finished result is less than perfect. Recently a patient was making a claim through a solicitor for an ongoing periodontal condition and a report came back from her expert practitioner that a root filling was inadequate on an upper third molar because it was slightly short of the apex and would have to be redone, despite me getting the patient immediately out of pain some ten years previously and the tooth having remained symptom free ever since, and showing no signs of periapical pathology.

Congratulations to Dr Burton for providing excellent care, but what would he have done if those young ladies had turned up claiming benefit and not being able to afford his treatment costs – might he too have been tempted to employ also a degree of 'diagnosis tosh'?

P. R. Williams, Lowestoft

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RISKY QUANTITIES

Sir, I read with great interest the letter to editor entitled *Herbal interactions* (*BDJ* 2010; **209:** 57). There has been an increase in the use of herbal medicines around the world in recent years in the general belief amongst the public that they are safe because they are obtained from natural sources. However, some of these products have associated adverse effects. Ginger contains gingerols and shogaols that prevent blood cells from clotting and acts as a natural blood thinner. Similarly, garlic is extremely beneficial to the entire cardiovascular system. Chemicals named alliin, allinase, and allicin present in garlic improve blood circulation by thinning the blood.

Ginkgo and Ginseng herbal supplements are widely used in Europe and the United States to treat circulatory disorders. Ginkgo leaves contain two types of chemicals (flavonoids and terpenoids). Flavonoids protect the blood vessels from damage and terpenoids improve blood flow by dilating blood vessels and reducing the stickiness of platelets. Though all these herbal medicines have a beneficial blood thinning action, especially in heart diseases, they can be risky to consume in large quantities. The blood thinning effect of these natural products may lead to bleeding from the gums, nose, in urine, stools and bruises. Hence, patients should never start self medication and combine artificial and natural blood thinners without consulting a physician. These herbal supplements should be stopped by the patients at least 36 hours prior to surgery or dental procedures due to the risk of bleeding complications. The medical history taken by the dentist should include questions regarding the taking of herbal and over-the-counter medications.

A. Parolia, by email

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A FUNDAMENTAL COG

Sir, Arianne Matlin and Damien Walmsley (*BDJ* 2010; **209:** 261) correctly highlight the common risk factor approach as being the strategy which is roundly accepted as the prime strategy of choice in the development and implementation of dental public health interventions. The voices extolling this approach have been evident for many years,[1-3] however, the question remains as to the proficiency with which (if at all) this approach has been taught at an undergraduate level and whether dentists and dental teams subsequently feel empowered to use this in primary care settings. Crucial for dental teams is the use of expertise and resources based within dental public health/oral health promotion, which requires ongoing clinical engagement. Making this relationship more robust where lacking should improve the quality of oral health promotion disseminated by dental teams in primary care.

The BDA's call for commissioners to understand the needs of prisoners is a principle worth dwelling on with a broader perspective. In order to appropriately and effectively develop public health interventions for most 'difficult to reach' communities or populations, understanding them has to be the crux. Too often as clinicians we look at and treat our patients through our own vision of the world with our own cultural values. To understand a population, a community, a member of the public, is to be able to look at an aspect of their life, in this case health, through their own value systems. Doing this enables us to best provide effective interventions that may have a greater impact.[4] The ability of a clinician to be culturally competent whether in public health or any other clinical field will help improve the responsiveness of patients to their interventions. The depth of understanding of cultural competence needs to be brought into the undergraduate curriculum. After graduation and in PCT land, tick box exercises in cultural awareness are too common and often a totally inadequately substitute for cultural competence. For clinicians informing commissioning decisions, cultural competence must be a fundamental cog helping them interpret local conditions.

K. Anis, Middleton

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DOI: 10.1038/sj.bdj.2010.1094