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.

NEEDLESS WASTE

Sir, having been forced to give up my career in general practice in April 2008 following being diagnosed as HIV positive, I follow with interest the latest developments relating to the subject of HIV positive dentists in the UK and the current Department of Health policy, brought into being in 1991, that prevents dentists like me from performing any clinical work that is classified as being an Exposure Prone Procedure (EPP).

Knowing, and very much fearing, the fate of dentists in the UK who become HIV positive together with my desire to continue to work in my chosen profession, I attempted to keep my diagnosis a secret and continued to practise for some months after finding out my status. I was very well aware that I was going against current guidance by doing so and knew that this guidance stated that 'HIV infected healthcare workers must not rely on their own assessment of the risk they pose to patients'. However, I was also very much aware that I was not the only HIV positive healthcare worker who kept the same secret. I personally knew of several other EPP-performing healthcare workers, including dentists, who did the same. Indeed, the off-the-record advice given to me immediately after my diagnosis from one acquaintance, a consultant in HIV medicine, was to 'keep your head down and don't tell anyone.'

However, my plan to keep my status hidden was short lived after someone that I trusted with my secret passed the information to a national newspaper. I was confronted by the local Consultant in Communicable Disease Control with the allegation and I admitted my status. A sensationalised story in the newspaper quickly followed, disclosing my full identity and photograph, followed by my inevitable summoning before the GDC Professional Conduct Committee.

The case, which was held in private, was eventually concluded in July with me being fully restored to the register without conditions. In its determination, the committee, having been informed by expert opinion that supported my ability to practise as an HIV positive dentist with no risk to patient safety, stated:

'The committee accepts that that the risk of transference of the HIV virus (from infected dentist to patient) is regarded by contemporary medical opinion as negligible, provided appropriate safeguards are in place.'

Of course, I'm still expected not to practise any dentistry in the UK that is regarded as exposure prone; however, given that the GDC now accepts evidence that an HIV positive dentist can practise safely, as they can do in the USA, Australia and much of Europe (where I could practise without restriction), it is very disappointing that the UK continues to adopt this zero-tolerance policy towards HIV positive dentists performing EPPs.

Contemporary cross infection control measures along with highly effective treatment for HIV infection which reduces blood viral levels to below detectable levels supports the existing worldwide epidemiological evidence that HIV positive dentists pose a negligible HIV infection risk to patients. It is extremely distressing that I continue to be considered a threat to public health in doing the job that I trained hard for and one which I love and miss very much. Being HIV positive has resulted in my skills being wasted and it is frustrating that increasing evidence and expert opinion states that this needn't have happened. I have found that redeployment opportunities for HIV positive dentists in the UK to non-clinical roles within dentistry are sadly lacking and I wonder what influence the current policy is having on this situation in its potential to perpetuate stigma and facilitate discrimination against dentists like me. Despite my situation, I continue to pay my annual fee to the GDC and remain on the register as a redundant HIV positive dentist unable to make a living from my profession. Knowing first hand their opinion on the matter from my own conduct case, I urge the GDC to take a bold arms-length stand against the current Department of Health policy and take action to end this needless waste of a valuable healthcare resource.

A. Peters Reid, London

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INFANT ORAL MUTILATION

Sir, the oral health charity, Dentaid, wishes to increase awareness amongst UK dental practitioners to the possibility of seeing the consequences of Infant Oral Mutilation (IOM) in patients born in Africa or with African parents.

This traditional practice of gouging out deciduous tooth buds (perceived to be 'tooth worms' causing diarrhoea and fevers and thought to be potentially fatal) is carried out in at least ten African countries. The unhygienic methods used can cause septicaemia, tetanus, transmission of blood-borne diseases such as HIV/AIDS, and can be fatal. Orthodontic and other sequelae have been reported in immigrant patients living in Israel, Sweden, the UK, USA, Australia, France and Norway.

Clinical presentation: When a child presents with missing primary canines it

is most likely to be due to him/her having had treatment for 'tooth worms', as congenital absence of deciduous canines is very rare in African children. The most common presentation is absence of the primary canine, the majority being from the mandible, being three times more common than in the maxilla. Hypoplastic/dysplastic canines are also an indicator as, when the primary tooth is being enucleated, the permanent successor tooth can be damaged.

Other dental presentations are:

- Missing mandibular primary lateral incisors
- Peg shaped incisors or canines
- Retention of primary lateral incisors, with distal eruption of permanent successors
- Displacement and impaction of permanent canine
- Missing lower permanent incisors
- Failure of development of permanent canine
- Compound odontoma
- Orthodontic complications.

A detailed and regularly updated overview of IOM and photos of orthodontic consequences following the practice may be accessed at www.dentaid.org/resources/iommaterials.

In view of the worrying possibility that traditional healers who perform IOM may also be amongst those who have emigrated to the UK and may be still carrying out this practice (which is deeply entrenched in local beliefs), Dentaid would like to hear from any GDPs or orthodontists who would be willing to take part in a simple survey to investigate this, or who have identified IOM as a cause of malocclusion or missing/damaged permanent teeth. Please contact me on rosemary@dentaid.org for further details.

R. Longhurst, Exmouth
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IT IS REPREHENSIBLE

Sir, I would like to thank R. Moore (*Hypocritical tosh; BDJ* 2010; **209:** 265) and R. Elvin (*Check the facts; BDJ* 2010; **209:** 367) for responding to something I feel passionately should be aired.

I humbly take on the chin the accusation of listening to patients, except that I know one of them personally. I'm not sure how I would apply my molar rcf skills for the NHS fee, so I want to highlight the problem rather than point fingers (casting first stones and referring to black kettles comes to mind). However, whether you think a £500-£600 fee for a 2+ hour molar root treatment is outrageously expensive, or that patients have the right to expect a proper professional root filling, following 'best practice' for the NHS fee, the nub of my concern is that I feel it may be dentists who make that decision.

Can it really be right to tell someone their tooth can't be saved, when it can? If I went to the doctor with an in-growing toenail I'd be a bit miffed if all I was offered was amputation.

As I understand the meaning of 'professional', it is someone who does their very best for the patient, without concern for self interest or the interests of staff and colleagues, financial or otherwise, even when they don't feel like it.

I have the greatest respect for colleagues who can cover expenses for this fee, and take the time and care necessary to perform molar root treatments, or who couldn't opt out of a system which forced this on them. I'm sure one can justify telling a patient their tooth can't be saved, and that extraction is the only choice, but I can't be part of that system (my expenses exceed this figure!).

A quick price check for three k-flex, an endosonic, five NiTi rotary files and three thermafils, exceeds £45.60 and that's not including rubber dam, EDTA, sealant, X-ray films/processing, final filling, DSA and receptionist time, etc (perhaps colleagues can correct me on the figures). If one used just files and lateral condensation surely it would take longer. The ESE quality guidelines stipulate rubber dam, pre and post-op radiographs etc, and the general consensus is that however quick the mechanical preparation, the biological preparation should be a minimum of 30 minutes' disinfection, usually by sodium hypochlorite, this is after preparation and before filling, so even a speedy prep, say ten minutes (including LA) and a five minute filling gives a minimum of 45 minutes. So the NHS must be assuming that dentists are happy to make a loss on this (I will apply this technique to my plumber's estimate...)

Bottom line, it is reprehensible that highly trained professionals, as we all are, who undertake complex, intricate, delicate, often inverted work, using sophisticated techniques, should be held to ransom by a system which simply dictates a fee. Was it a bit like the Al Capone method? '..your signature or your brains on the contract..' (For brains read livelihood of course.)

Very proud to be hypochloritical.

D. Burton
By email
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AN ELEGANT SOLUTION

Sir, I agree with the views of Dr R. Piper (*BDJ* 2010; **209:** 264) except in one respect. The GDC is not wasting *their* resources in the pursuit of this nonsense, but *ours* as the registrants who fund them.

If the title of 'Dr' must go then an elegant solution was suggested in the letters pages of the *BDJ* many years ago. We should simply adopt the title 'Professor'. This would have the splendid effect of annoying both the medical profession and many of my Professorial academic colleagues. It was also pointed out that Professor Jimmy Edwards, the comedian, actor and tuba player had used the title for many years, apparently without any legal repercussions.

J. R. Drummond, Dundee
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SPECIALIST FEES

Sir, if you are on one of the GDC specialist lists and are therefore expected to pay the £72 specialist list fee in addition to the 'Dentist Fee' of £576, you may (like me) still wonder what this fee is for.

Using the Freedom of Information legislation, the GDC have confirmed that since the specialist lists opened, only five 'specialist list' registrants have been suspended and two have been erased.

Clearly specialists are not likely to come to the attention of the GDC under the fitness to practise procedures so why is there any need for a specialist fee?

G. McIntyre, Dundee
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