Russian, Spanish, Swedish, Tagalog, Thai, Turkish, Ukrainian, Urdu, Vietnamese, Yiddish, Yoruba).

These are freely available from the website (http://dental.pacific.edu/Professional_Services_and_Resources/Dental_Practice_Documents.html) in PDF format and can thus be stored on a local computer. The overview is provided at http://dental.pacific.edu/Documents/dental_prof/overview.pdf.

The true usefulness comes from the same question number asking the same question in all languages. Thus if a person circles 'yes' to question seven, the dentist will know that the patient has angina. It does not matter if the dentist can eg only speak English and the patient eg can only speak Russian, a reasonably comprehensive medical history may be obtained.

As there is no copyright on the documents (they are being freely given to the dental profession in an altruistic way) we commend them to be used as an easy way to improve patient services and communication, especially where official translator services may not be immediately available.

K. I. Wilson, J. Clarke MBE, V. Cooper
Birmingham
DOI: 10.1038/sj.bdj.2010.680

DIAGNOSIS TOSH

Sir, recently two young ladies, in their late 20s, attended separately here for private molar root canal treatment. They had both been seeing different local NHS practices and both had been told that the teeth in question were untreatable and had to be extracted. One had been, and still was in a fair amount of pain, and had been given a course of antibiotics for her hyperaemic pulp (which needless to say didn't work) and was told to book for the extraction in a few weeks. One was actually told that the tooth was far too decayed and root filling would be too costly and painful.

In the words of the prophet, 'what a load of old tosh'. The teeth were cariously exposed but eminently treatable, which is what we did.

Something's wrong somewhere!

D. Burton
Leatherhead
DOI: 10.1038/sj.bdj.2010.681

LIP SEALS

Sir, the lips are a significant aesthetic feature of the face, which serve important functional roles in phonation and the formation of an anterior oral seal in swallowing. Lip posture may be defined as the characteristic way in which an individual maintains their normal lip position in repose, ie with normal muscular tone and without excessive muscular contraction. The orolabial soft tissue posture is characteristic of each individual and, under normal conditions, each individual will achieve a lip seal in the rest position. If a lip seal does *not* occur, adaptive postures are used with almost continual contraction of the circumoral musculature in order to maintain an adequate lip seal.

Throughout dentistry, the term 'competent lips' implies that the lips are able to contact one another without strain when the mandible is in rest position. The term 'incompetent lips' implies that the lips are unable to form an adequate seal under similar unstrained conditions, ie excessive separation of the lips at rest. As a general guideline, which holds for all ethnic groups, lip separation at rest should be no more than 3-4 mm; above this, the lips are termed incompetent. The terms 'potentially competent' or 'pseudo-incompetent' are used to describe lip posture when the maxillary incisors are interposed between the upper and lower lips and the correction of the incisor relationship will permit normal lip posture.

In everyday English, the adjective 'incompetent' refers to an individual not having or showing the necessary skills to do something successfully, ie a layperson's way of describing an individual as inept or somehow inferior. Unfortunately, the common stereotype of the individual with increased lower face height and incompetent lip posture is that of an individual of low intelligence; the bully's taunts often follow suit. As such, it may be advisable for clinicians to avoid using the terms lip 'incompetence' or 'incompetent' *in the presence of patients*, particularly younger patients, as this may result in causing unintentional offence. Better terms to use, which are arguably clinically more accurate, are 'complete', 'potentially complete' or 'incomplete' lip seal.

F. B. Naini
London
DOI: 10.1038/sj.bdj.2010.682

NHS RESPONSIBILITY

Sir, I write regarding the article on caries control in health service practice (*BDJ* 2010; **208:** 449-450). Under the heading of the practicalities of implementing the toolkit under the UDA system of payment, the author mentioned the patient being a victim of deceit by the system. I agree completely that 15 minutes for everything that is expected is near impossible, but the responsibility for doing it rests with the individual practitioner. If we do not fulfil our commitment to the system, it is our practice that is unethical, not the system. We have accepted the terms of service when we committed to carrying out treatment under such a system and therefore the responsibility of patient care rests with the practitioner and not the system.

For £24 and in 15 minutes, patient care is of utmost importance, yet difficult to achieve. Therefore to tick all the boxes, we are forced to spend more time on the patient for the same amount of money. If we do not care for the patient appropriately, the responsibility falls on us, not the system. In our heart of hearts, we all have a similar complaint but if we have committed to providing treatment under this system we have accepted responsibility.

After all, as far as figures and targets are concerned, NHS access has improved and the government has to some extent achieved what they wanted to. Whether we complain about or condemn the system, the targets have been achieved by us. We need to take responsibility and not blame the system and make patient care an excuse. In this climate of recession more of us have turned to the health service for our income security. That seems to mean more to us than the future of our profession. No one is being deceived, the dentists are being used and we are continuing to allow it for whatever reason.

M. Shahid
By email
DOI: 10.1038/sj.bdj.2010.683