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.

A LOT OF EXPENSIVE NOISE

Sir, when I was a student in the early 1970s, I remember a lecture about our future lives in dentistry, when 'Bodies Corporate' were discussed. As I remember it, we were told that these had been discouraged/made illegal between the wars as they put undue pressure on dentists to meet targets which were set by directors who only had their own profits in mind.

History does teach us a lot about the present day. The difference now appears to be that as long as access issues are addressed, the NHS is happy to turn a blind eye to the quality of service which they commission.

I have worked as a locum in and around my area for the last six years and I am dismayed by, and sometimes ashamed of, the lack of care provided to patients because of the UDA system. It is not universal, but it is prevalent where there is no leadership.

This has been alluded to by recent correspondence in your journal and I feel I have to share some of my experiences.

As a generalisation, decayed roots are left, even with a draining sinus, unless actively giving the patient pain, when they may be referred to hospital. Root fillings are not undertaken unless the patient insists, and many times they are told it is either beyond the dentist's abilities, so they are referred privately to a specialist within the organisation, or they are told the success rate for RCTs is low and may well not work, so extraction is the best option.

Scales and polishes are ignored. Occasionally if the patient is having other treatment it may be slipped in, but as a rule no proper oral hygiene treatment is given. Referral to a hygienist is an option privately, but many patients cannot pay, so their oral health deteriorates further.

I have seen an acrylic lower partial 'gum-stripper' denture made for a patient to replace the lower left first molar. This was the only option offered to a woman who had had the tooth extracted and was worried about the gap.

Inlays are a very quick and easy way of getting 12 UDAs. One dentist I remember in particular did them with no preparation or even removal of plaque from the cavity. She may have been extreme, but many patients seem to need just one filling, even where several cavities can be seen with the Mark I eyeball. If the 'box' part of a class II amalgam fractures it is generally patched with glass ionomer. When this falls out or wears away, the rough edges are stoned and the patient is told that it is obviously not going to take another filling and it is better to smooth it than take it out.

The staff are usually unqualified, except the Senior DSA. There is an online training scheme for DSAs in at least one of the corporates, but no support and little incentive for the staff doing it, so in my experience they give up.

The managers have no background in dentistry and therefore have no idea about clinical standards. They manage the targets, not the people and make sure that the ticks that the PCT wants to see are there. If your experience is in the greetings card industry I fail to see how this can be useful to clinical standards in a profession. The Purple Ronnie Practice, perhaps.

These are general observations but, thank goodness, are not universal. I could add to the list of failings I see, but what worries me is that there appears to be no-one checking standards. Patients receive questionnaires to check the NHS is not being defrauded, but I have seen little evidence of checking that the patients are not being defrauded.

The GDC reacts to patient complaints, but does little to prevent the complaints in the first place. It appears to me to be what Formula One is to motoring – a lot of expensive noise and spectacle but with little relevance to the everyday.

Ultimately it is the patients who suffer. They are often happy to find any NHS treatment and do not know whether it is good treatment or not, but they should expect the 'daughter test' ie, would I, the dentist, do this treatment on my own family? The bulk of the general public is being hoodwinked.

There is a great chasm opening between NHS treatment and private. This does not hold true in small, independent practices where the principal has a feeling of pride for his or her work and that of his or her team. However, these appear to be dwindling and industrial dentistry has taken over the NHS as small practices sell out to big business.

I was also taught that the first duty of a profession is to uphold professional standards, so we appear to be failing in our duty.

A. Sorrell, Alton

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POLITICALLY DRIVEN

Sir, we thank Dr Renton for her considered commentary (*BDJ* 2010; **209:** 36-37) on our published article (*BDJ* 2010; **209:** E1). There is a paucity of data on the subject of complications in relation to third molar surgery and the numbers of patients included in this study are as large as any in recent times. It is a pity that this paper was viewed in isolation, as many of the points that were raised on study design, level of supervision and surgical difficulty

were dealt with in previous papers published by our group.

We are disappointed that this discussion has been hijacked into a debate on academic oral surgery versus oral and maxillofacial surgery. Third molar surgery is an integral part of training in oral and maxillofacial surgery as well as academic oral surgery and any attempt to differentiate between the two in terms of training or supervision is a politically driven speculation.

We recognise that these views do not reflect all dentists or academic oral surgeons who work very effectively in teams with oral and maxillofacial or head and neck surgeons. We agree that academic oral surgery is a growing speciality but realise that oral maxillofacial/head and neck surgeons as yet still provide the bulk of general anaesthetic operative third molar surgery. Many of these difficult cases may present with medical complications which may be better dealt with by specialists with training to recognise and deal with these problems. These are also the specialists to whom cases are referred when serious untoward events occur; to think otherwise may be disingenuous and raise medico-legal expenses. The risk of alienating our dental practice and oral and maxillofacial/head and neck colleagues does not serve the interests of patients, multidisciplinary teams or the NHS. We firmly believe in the multidisciplinary management of patients with no one speciality having provenance. Patients should be at the heart of all our actions, not speciality or self interest.

Despite the thought that this surgical training should occur in just the academic oral surgery setting, on analysis the same difficulties in training would arise. Similar problems also manifest in ENT treatments or any discipline that does not allow simultaneous direct visual access by trainer and trainee. We would be interested in the training methods indicated by the commentator so that this practice could be shared and disseminated for the benefit of all.

In summary, the patient's best interests come first. Working in a team of dentists, academic oral surgeons, oral and maxillofacial and head and neck surgeons would enable providing the best care and optimal medical/surgical managements of postoperative complications.

W. Jerjes, T. Upile, C. Hopper, London

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INCORRECT AND MISLEADING

Sir, I think the GDC is right! In my country (Germany) a 'Dr' is someone with a PhD. No exemptions made. Dentists and physicians can obtain a PhD and then they can call themselves a 'Dr'! Otherwise there are just dentists or physicians. Additional academic efforts with years of reading, studying and practical work should have some reflection and reward. I never understood why every dentist or chiropractor calls themselves a 'Dr' here in the UK. It is simply incorrect and yes, misleading to the public and the 'real' doctors.

Funnily enough I have obtained a doctorate or PhD in Germany for which I studied for four years with Public Dissertation and so on but the GDC doesn't accept that as an additional qualification ... never mind.

P. Nelz

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NON-ACCIDENTAL INJURY

Sir, we wish to highlight a confirmed case of non-accidental injury in a 3-month-old boy who was bought to the attention of social services by the oral and maxillofacial surgery team at Central Manchester and Children's University Hospitals NHS Trust after presenting through the Paediatric Emergency Department. On examination the patient had a semi-lunar, scarred ulcerated lesion on the floor of his mouth which raised concerns of thermal or traumatic injury. There were no other marks or bruises on his body. With written consent from the patient's mother, a full child protection assessment was undertaken. A number of unexplained skeletal injuries were disclosed through radiographic examination including skull, vertebral, rib and tibia fractures. The patient did not have any clinical signs of osteogenesis imperfecta or other bone disorders.

Various studies have shown that as many as 50-75% of all cases of child abuse involve trauma to the mouth, face and head. Consequently, dentally trained professionals are ideally situated to identify cases of non-accidental injury and should feel supported in raising their suspicions. Victoria Climbié and Peter Connelly ('Baby P') are well known cases of child abuse that may have been preventable had the relevant bodies been more vigilant and reported their concerns.

The warning signs of abuse should be considered every time an injured patient is seen. Repeated injuries, multiple bruises, or injuries with uncertain explanations may signal instances of abuse. If there is any concern about a child patient's safety, all dental practices/hospitals should have a child protection policy in place and protocol for prompt referral to the local social services child protection team.

N. Patel, P. Sen, W. Allen

Relevant reading

1. Harris J, Sidebotham P, Welbury R *et al. Child protection and the dental team: an introduction to safeguarding children in dental practice.* COPDEND, 2006. www.cpdt.org.uk
2. Becker D B, Needleman H L, Kotelchuck M. Child abuse and dentistry: orofacial trauma and its recognition by dentists. *J Am Dent Assoc* 1978; **97:** 24-28.
3. Sinha S, Acharya P, Jafar H *et al. The management of abuse: a resource manual for the dental team.* pp 86-87. London: Stephen Hancocks Ltd, 2005.
4. The Lord Laming. The protection of children in England: a progress report. The Stationery Office, 12 March 2009.
5. Naidoo S. A profile of the oro-facial injuries in child physical abuse at a children's hospital. *Child Abuse Negl* 2000; **24:** 521-534.

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WAKE UP TO ENDODONTICS

Sir, in reply to D Burton (*Diagnosis tosh*; *BDJ* 2010; **209:** 106) I could not agree more.

The standard of endodontics in the UK is appalling with most practitioners looking upon such treatment as a last hope before the extraction of the tooth. I have even heard colleagues explaining this to their patients. The advice is usually along the lines of 'we'll give this a try but it doesn't often work and at least we will know we tried'.

Of course, I blame the current remunerative system of the NHS, which does little to reward routine work let alone something as complicated as good endodontic treatment but the fact is that endodontics remains the poor relation in the glamorous world of implants, whitening and invisible braces.

Yet patients will gladly pay upwards of £2,000 for such treatment. By comparison, the endodontic treatment of a molar tooth is, on average, in the region of £500 - and you get to keep your own tooth!

Modern endodontics is about predictability. With good endodontic treatment most teeth can be saved with a predictable success rate.

It's about time the profession woke up to the real contribution that endodontics provides and not simply write teeth off that have an exposed pulp.

The future of endodontics is exciting, far more so than that of the implant. In the world of endodontics we are giving serious thought to regenerating the pulp that has died.

I implore all colleagues in general practice to think about this before they condemn another tooth to the bin.

S. Cowling, Oswestry

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TEXTBOOKS WANTED

Sir, dental students at Malago Dental School in Uganda are finding textbooks nearly always too expensive to obtain. The charity Christian Relief Uganda (CRU) is appealing to readers to offer any textbooks or DVDs they can spare to be sent out with its dental missions in November and in April 2011. Please contact Barbara Koffman, CRU's dental coordinator, at bkoffmancru@hotmail.com with details of books/DVDs available. Thank you so much.

R. Longhurst, Exmouth

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GAPING GOB REVEAL

Sir, a literary-minded friend recently commented that he has toyed with writing a poem based on a dental check up. He has noticed a certain metre to the words we so often incant! Having supplied him with a few technical terms, he returned the following to me. I thought it was rather splendid and would like to share it.

How Gerard Manley Hopkins may have written up a dental examination:

OPEN WIDE
Cavernous cavity of gaping gob reveal
enigmatic enamelled elements;
delirious dentine of smiley-smirk
pearl lustre.

Number nominal, in mirror reflect
mesio-occlusal, buccal abrasion,
palatal composite
gnash, grind, rip, tear, chew;
as pontic and abutment bridge and thus,
oh! redeem sick-sherbert-sweet
induced decay.

John Smith

He promises a sequel - in the style of John Betjeman!

A. Chapman, By email

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MUSCULOSKELETAL PAIN

Sir, I read with great interest the summary of the research on dentists and ill-health retirement by J. Brown *et al*. (*BDJ* 2010; **209:** 218-219). I must confess I permitted myself a wry smile on reading 'The most common cause of ill health retirement was musculoskeletal disorders.' (*Sic*)

I wrote my first article on that subject in 1964! Since then in hundreds of articles, lectures, courses and two books I have continuously campaigned (and still am) to get the message across that musculoskeletal disorders are PREVENTABLE.

This is by working in correct, undistorted posture and using their dental nurse far more ie team dentistry. Professor Newton rightly highlighted this in his excellent summary. It is sad that whilst there are many hundreds of dentists who have taken my message to heart and implemented it, too many others have not. One problem is that they accept back pain as a fact of dental life and so feel it is unnecessary to learn there is a remedy - until it is too late.

In addition I am constantly appalled that so many of the students and DF1s that I regularly encounter are already suffering pain because they are not being taught how to prevent it in dental schools. This is an unacceptable situation.

I hope this survey will now stimulate every dental school to put this omission right by incorporating the teaching of perfect posture and team dentistry into their curriculum and that it is continued into the DF groups.

The extra cost this will incur will pale into insignificance when compared to the enormous cost to the country of losing hundreds of dentists through having to retire prematurely - to say nothing of the additional cost incurred by dentists being absent from work because of musculoskeletal pain.

E. Paul, By email

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