extra finance of multiple hospital visits, car parking charges and ever increasing cost of fuel, often in our area up to a hundred miles for a round trip to access a regional centre care.

To make additional decisions around the possible loss of a number of teeth, or in some cases a posterior dental clearance, to reduce the risk of BRONJ and cope with the treatment can be one decision too many with which to cope. A significant amount of time is usually required to give appropriate holistic and pastoral support for their decision making. Then to add to this that they need to pay for the 'privilege' of receiving this care, I think is of concern. I am not suggesting that dental treatment should be free for life as the constraints on funding for NHS care are of course significant for the foreseeable future. However, free dental care for their time of most need would seem appropriate in my eyes.

G. Greenwood
By email
DOI: 10.1038/sj.bdj.2012.731

FLAWED PENSION SCHEMES

Sir, career average earnings pension schemes seem acceptable for general dental practitioners considering most of us will wind down in our older years of working life. This system is great in theory but in practice the system is flawed, especially for GDP associates.

The annual reconciliation report (ARR) is a declaration by the principal regarding the associate's pensionable earnings for that year alongside their own. We place our trust in principals to complete these declarations accurately and honestly. A discrepancy between declared and actual pensionable earnings may result in the associate receiving less pension than their entitlement.

Having experienced this several times, GDPs should be urged to check their schedules and check with NHS BSA that the correct figures have been declared for their performer number.

Miscalculations are being made either through principals' lack of understanding of NHS pension rules or through fraudulent behaviour. Despite much publicity from the BDA about this, it seems many NHS associates have not taken it upon themselves to firstly verify their declared earnings let alone challenge it if a discrepancy is noted. The pension one accrues as a GDP is wholly dependent on the figures entered on these forms.

Informal discussions with numerous dental associates leads to me to believe that the majority of them place no great emphasis on pensions either through ignorance or lack of understanding. This may ultimately be detrimental to their pension fund yet be an additional 'unearned bonus' to their principals.

J. Balachandran
By email
DOI: 10.1038/sj.bdj.2012.732

UNJUSTIFIED VINDICTIVENESS

Sir, there is anger and frustration nationally about the role of NHS Choices and the frustrating lack of editing rights and ability to challenge comments put on there. I would like to update your readers regarding our recent experience with a vindictive patient who commented adversely and unfavourably towards us.

We had not had any comments put on NHS Choices until recently when a patient of our practice was denied access to NHS services as they had failed to attend repeated appointments. Under our agreed policy with the PCT (in contract) we were allowed a 'two strikes and you are out'. The patient came in and gave my manager grief over this issue. Alerted by the commotion of the patient's raised voice, I remained hidden within earshot to listen to the conversation. My manager behaved remarkably coolly and in line with our difficult client management training, organised by our PCT! The patient left and said that she would let it be known that we were a rubbish practice.

Two days later we were statutorily informed by the PCT that a comment had been placed on the NHS Choices website. The comments were awful, saying that the staff were rude and impolite and so on. These are not reflective of our practice. The adverse comments are easily visible to any prospective new patient and only two clicks away when you Google our practice and my name. We obviously knew who it was.

We had previously carried out three patient surveys/audits in the past five years, two in-house and one independently carried out by Dr Foster Intelligence on behalf of our PCT over a six month period. In all three surveys we scored above 90% satisfaction across of all areas of patient contact with our practice.

I contacted the moderator of NHS Choices and put my case across, outlining our good feedback history and applied to have the comment struck off as it was clearly unjustified vindictiveness against us. The request was denied and I was told it has to remain; to this day it is still there. Having heard from my LDC that this was an ongoing frustration with other GDPs nationally, I decided to do something about it. The only way was to drown the patient's comments by proactively asking patients in the subsequent week if they would comment on NHS Choices about their experience with us.

I was then contacted by the PCT informing me that I was an outlier in the high volume of comments on NHS Choices which were positive. I was informed that they would not likely be allowed to remain. I was livid! This is unfair! After explaining the issue, I asked for the details of the ombudsman overseeing NHS Choices. As I said I would take this further it looks like the PCT have now decided to allow the positive comments to remain.

We have successfully drowned the adverse comments in a sea of praise about 18 clicks deep.

This whole episode questions the value of NHS Choices. I have had to resort to gamesmanship to challenge someone else's unjustified comments and protect our reputation.

M. Hussain
Catford
DOI: 10.1038/sj.bdj.2012.733

GUN PELLET RADIOPACITY

Sir, a 51-year-old patient was referred to the maxillofacial department by his general dental practitioner due to 'an object lodged between UL7 and UL8'. On attendance he gave no history of injury to the area, and was symptomless. On examination it was noted there was a

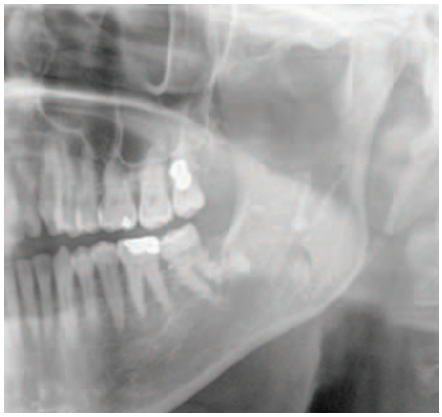

Fig. 1 OPG Showing foreign body in the UL8 region

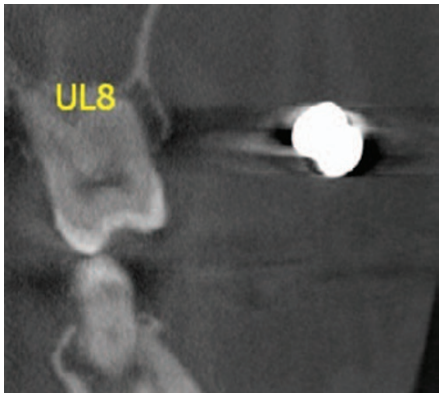

Fig. 2 Coronal cross sectional image of cone beam CT scan displaying foreign body position within soft tissues

small scar/blemish of the skin overlying this region; the remaining clinical examination was entirely normal. Radiographic evaluation in the form of an OPG radiograph was arranged. The resultant image displayed what was initially thought to be a radiopacity (with recurrent caries) associated with a heroic attempt at restoring UL8. Further examination and consideration revealed that this was not the case. A cone beam CT scan of the area was arranged, which revealed a metallic foreign object of a shape consistent with an air gun pellet. The suggestion of caries was entirely artefactual. The object was 8.5 mm by 5 mm in size and was positioned at the anterior body of the masseter muscle (just clear of its surface), 15 mm anterior to the mandibular ramus, at the level of the root apices of the maxillary molar teeth. The patient denied ever having sustained any such injury and wished to leave the foreign object *in situ*.

P. Serrant, Wigan
R. Mani, S. Clark

DOI: 10.1038/sj.bdj.2012.734

TIME BEST SERVED

Sir, currently working as a DF2 in oral and maxillofacial surgery (OMFS), I have become aware of a potential change in regulation for medical graduates hoping to study a dental degree in preparation for a career in OMFS. Presently, a postgraduate degree in dentistry for doctors is four years, however, this is under review.[1] An EU requirement states that a dental course must be five years in duration and a previous degree cannot contribute to this. This is despite the first year of dental and medical school being more or less synonymous, both focusing on basic human sciences, molecular and cell biology. This requirement is also being examined by the European Commission and a verdict regarding whether it will remain in effect is expected towards the end of this year.

If the postgraduate degree in dentistry for medical graduates does increase to five years, this will undoubtedly result in fewer prospective OMFS trainees due to increased financial consequences from student fees and loss of income. What long term effect will this have on the speciality of OMFS? Will there be greater non-UK trained maxillofacial surgeons being employed in the NHS, who may not have training to UK standards or fewer maxillofacial units being replaced by major referral centres?

On another matter, I have noticed the effect that the European working time directive has had on OMFS and dental foundation training. This was introduced to prevent doctors being over worked, improve patient care and reduce mistakes made due to fatigue. This has, however, also resulted in less practical experience being available for trainees as they are not allocated to be on-call or in the hospital as often.

Speciality trainees are given the priority in training and are less likely to give opportunities to DF2 trainees, as they are eager to enhance their own limited surgical experience. Additionally, more DF2 trainees are required to be employed to delegate the workload, which further dilutes exposure. For young dental graduates, a year in OMFS is invaluable and excellent practice for working in a multidisciplinary team, improving management of medically compromised patients and diagnosis of various oral conditions. However, graduates must appreciate that they will receive limited surgical experience and to significantly improve their skills in oral surgery, their time may be best served in a dental hospital.

S. Kaura
Derby

1. King's College London. Dentistry Entry Programme for Medical Graduates (subject to approval). http://www.kcl.ac.uk/prospectus/undergraduate/details/name/dentistry-entry-programme-for-medical-graduates (accessed August 2012).

DOI: 10.1038/sj.bdj.2012.733

FOR THE RECORD

Sir, we are writing in response to A. Maqbool's letter *Interpretation consideration* published in the *BDJ* (2012; 212: 304). Dr Maqbool states that there is an error in our paper *A guide to entry into specialist training* (*BDJ* 2012; 212: 35-40) regarding eligibility to enter the MFDS Part 2 examination given in Table 3 on page 37. The regulations for MFDS published jointly by the Royal Colleges of Glasgow and Edinburgh state to be eligible to enter MFDS Part 2 candidates must provide evidence of:

'a) written confirmation of a pass in Part 1 in either the MFDS (Edinburgh, Glasgow), or other examinations accepted by and detailed on the websites of the two Royal Colleges;

b) completion of 12 months' full-time postgraduate experience in clinical dentistry before the closing date for entry to Part 2. Normally, equivalent part-time experience will be acceptable if gained within a period of four years.'

S. Critchlow
L. Nanayakkara

Editor-in-Chief's note: I am grateful to the authors for setting the record straight on this matter and apologise for the oversight in not offering them the opportunity to respond in the same issue as A. Maqbool's letter.

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