Letters to the Editor

Send your letters to the Editor, British Dental Journal, 64 Wimpole Street, London, W1G 8YS
Email bdj@bda.org

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

Readers may now comment on letters via the *BDJ* website (www.bdj.co.uk). A 'Readers' Comments' section appears at the end of the full text of each letter online.

FREE TO INNOVATE

Sir, earlier this year Lord Saatchi launched his Medical Innovation Bill with the aim of changing the current culture within the profession that makes practitioners fearful of the new and untested. Under the heading 'The fear of being sued is ruining modern medicine' Dr Max Pemberton, in *The Telegraph* (10 December 2012) wrote that 'Evidence-based research, whilst noble in theory, in reality is not always realistic given the complex nature of some medical problems'.

Within the dental profession a similar dilemma exists particularly in the field of chronic head and neck pain related to dental occlusion and TMJ problems. Where mainstream treatments, such as rest, reassurance, night guards, analgesics and counselling have failed, the practitioner wishing to best serve his patients may wish to try methods which are not supported by evidence-based research.

'Frightened of litigation many practitioners do not push the boundaries of medical knowledge and opt instead for the "safe" standard procedures. This attitude is not good for patients who are denied the chance of cutting edge techniques when they have little or nothing to lose. It is not good for practitioners who are constantly questioning what they do or don't do – not on behalf of the patient, but because they fear having to justify what they are doing in front of cross examination.'

Practitioners are bound by professional guidance and their duty of care to their patients still remains. Where the evidence is shaky or wanting or not clear, then practitioners should be free to innovate, and this is what Lord Saatchi's Bill suggests. Let us hope for the sake of our long suffering chronic pain patients that more useful treatments will be accepted, rather than just 'learning to live with pain'.

R. Dean
By email

DOI: 10.1038/sj.bdj.2013.331

SHORT-LIVED BENEFITS

Sir, Dr A. Maini's article on short-term cosmetic orthodontics (*BDJ* 2013; **214:** 83) is appropriately named as the benefits of this approach to treatment in many cases are destined to be short lived. For the benefit of readers who may be seduced, orthodontists have learned the hard way that very few patients successfully sustain wearing removable retainers on a long-term basis. The great majority of adult patients need permanent retention, not just some night-time device for a year or two. The only reliable retainers for long-term use are palatal or lingual bonded wires which must be out of occlusion. In the upper arch, this means that overbite reduction is often necessary which usually means that treatment will take longer than six months and that full appliances will be required in both arches. One wonders how many quick fix patients are informed in a clear and unambiguous way that their few months of short-term orthodontics will be just that, short-term, unless followed by a lifetime of retention.

R. Kirschen
Reigate

Dr A. Maini responds: I completely agree life long retention is imperative with any adult orthodontics. All my patients have verbal and written understanding of the importance of retainers. If need be we can fit upper retainer wires by either minor lower incisor intrusion or by deep bite correction with levelling of the curve of spee. This can be done within the scope of short-term orthodontics.

DOI: 10.1038/sj.bdj.2013.332

PROVIDING A CHOICE

Sir, Mr Maini's article[1] states that 'short-term cosmetic orthodontics' is a treatment concept within the comfort zone of general dental practitioners. There are two issues that need to be considered: firstly, those related to consent, and secondly, the scope of specialist orthodontics.

Clinicians are ethically bound to have a full and open discussion with a patient regarding the relative merits and risks of all available options for treatment. Central to this report is the concept of 'providing a choice'. When there is only a limited choice available, however, this would seem contrary to our duty of care. Patients may not have occlusal problems as their primary complaint, but to dismiss comprehensive correction in favour of a cosmetic compromise, without full and impartial discussion, risks falling foul of the central tenet of informed consent. A comprehensive diagnosis is essential prior to providing fully informed consent. The taking of consent, before treatment begins, should be undertaken only by an individual who is aware of all the options available, together with the likely result if no treatment is undertaken, and the risks and benefits of all treatment options.

Short-term treatments have been and remain a valid treatment option within