

LETTERS TO THE EDITOR

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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.

DIRECT ACCESS

Conflict between sub-groups

Sir, I read with great interest the research article by Northcott *et al.* (*BDJ* 2013; 215: 607–610) relating to direct access for dental hygienists and therapists. As I read the article as someone who believed that they understood the current status of scope of practice and direct access, I was struck by how complex and confusing it actually is. At a time when the General Dental Council have proposed to remove the honorary 'Doctor' title from dentists so that patients are not confused and muddle us up with their GMP, it seems that patients may be put at risk by assuming that all levels of dental health professional have the same ability to screen, diagnose, order special tests and perform treatment. That is, unless a structured, integrated and collaborative approach is taken in which each member of the dental team has a clearly defined role.

In September, I attended a national conference at which I was joined, for the most part, by dentists. At that conference a programme director for a BSc in oral health sciences took to the podium to expound the benefits of using therapists as part of the comprehensive treatment of paediatric patients. Instead, the presentation seemed to be a call to train more therapists and fewer dentists. Whilst a lot of what was said was valid in terms of economics and indeed patient care, the delivery was very antagonistic towards dentists as a group. We were repeatedly told that therapists could do periodontal treatment and direct restorative work to a higher standard than dentists. We were reminded that, with training, many additional skills could be acquired by therapists that would render dentists surplus to requirements, perhaps with the exception of some advanced restorative work and complex dentoalveolar surgery. While a lot of the above may be true, it does not benefit anybody – patients, therapists, hygienists, dentists or taxpayers – if each group relentlessly seeks to promote their own role, skills and 'market position' to the exclusion of others.

What is needed is a mature, respectful and collaborative dialogue with patient care at its focus. Professional associations, regulators, academic institutions and policy makers must work together to develop a framework for the future delivery of dental care in the NHS which meets the needs of our patients first and foremost. The future dental workforce must be able to cope with our population's present and future oral health needs.

I am grateful that the authors of this study have highlighted some of the issues in the Netherlands in relation to direct access. I hope that as a group of dental healthcare professionals we can learn some of the lessons from the Netherlands to ensure that patient care is not compromised by conflict between sub-groups of dental professionals.

C. Levey
Glasgow

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ORTHODONTICS

Not a causative agent

Sir, I am writing to express my concern regarding your recent *BDJ* paper regarding prevention and treatment of demineralisation during fixed appliance therapy (*BDJ* 2013; 215: 505–511).

The body of the article correctly associates orthodontic fixed appliance systems as a risk factor in the development of enamel demineralisation. I further support their view that disregard of the aetiology and development of this process in orthodontic patients leaves clinicians at risk of being clinically negligent and the subject of litigation.

It was with some surprise therefore that I read Figure 1 showing a patient who has enamel demineralisation 'caused' by fixed appliances. This demineralisation has not been caused by the fixed appliance. It is associated with the process and is a risk factor in its progression but it is not a causative agent and there is not a cause-effect relationship between the two.

This misunderstanding of the relationship between orthodontic

appliances and enamel demineralisation sets a concerning precedent with the ever-growing threat of litigation from the legal profession. May I suggest an amendment to the paper to reflect an association rather than a causative effect between these two variables?

S. Lovel
Sunderland

Mr Colin Chambers, the corresponding author of the article, responds: Many thanks for your concerns regarding Figure 1 in our article. I would be more than happy to amend the Figure 1 legend to 'Demineralisation associated with fixed appliance treatment'.

However, the article does clearly explain the disease process that results in enamel demineralisation and should not result in any misunderstandings.

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PIERCINGS

Grossly swollen tongue

Sir, a 45-year-old male presented to the emergency medicine department from an ambulance with a 12-hour history of a grossly swollen tongue. The patient was experiencing difficulty in swallowing and shortness of breath. The severity of the swelling posed a risk to his airway and an anaesthetic opinion was promptly obtained. After administration of steroids and antihistamines the airway was assessed as safe and the patient was seen by the maxillofacial team.

He had a gastric band fitted, took no regular medications and had no known allergies. He could not recall eating any foodstuffs or taking any medications that could have triggered an allergic reaction. On further questioning the patient remembered that he had his tongue pierced ten years ago. The piercing was a stainless steel tongue bar with a spherical bead at either end of the bar. The tongue bar was removed by the patient soon after placement, but when the bar was removed only one of the beads was retrieved. To investigate further, a lateral soft tissue radiograph was taken. This