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.

MINIMAL INTERVENTION DENTISTRY

1970s glass ionomers

Sir, I was interested to read the paper on minimal intervention dentistry by Ngo and Opsahl-Vital (*BDJ* 2014; **216:** 561–565). The article states that glass ionomers were introduced to the dental profession in 1988. I believe it was much earlier. I still have my 'ticket book' given to all students at Guy's and in which all restorations and materials were recorded. In it I see that on 6.10.1977 as a third year student I did a restoration with ASPA – alumino silicate polyacrylic acid. I believe this was the first commercial GIC material, made by De Trey. On the ticket the demonstrator has noted that underneath it was my first pulp exposure. A cutting edge day for me in several respects.

N. Chandler
Dunedin, New Zealand
DOI: 10.1038/sj.bdj.2014.763

ORAL HEALTH

Antacid toothpaste

Sir, we came across this interesting advertisement (Fig.1) in *The Glasgow Herald* (7 November 1941). In the advertisement, the use of milk of magnesia toothpaste for 'smokers' fur' is advocated to get rid of the woolly feeling in the mouth caused by excess acid formation, and for a clean mouth and fresh breath.

Fig. 1 Advertisement in the *The Glasgow Herald* for the antacid toothpaste (Reproduced with permission from *Glasgow Herald*)

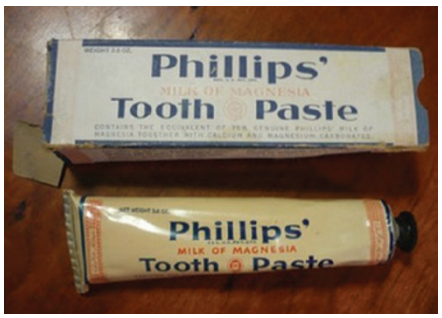

Fig. 2 Phillips Milk of Magnesia toothpaste

Milk of magnesia or magnesium hydroxide is an antacid used to neutralise stomach acid, and a laxative. It is primarily used to alleviate constipation and to relieve indigestion and heartburn. Charles Henry Phillips in 1872 coined the term 'milk of magnesia' which was a white-coloured, aqueous, mildly alkaline suspension of magnesium hydroxide and was sold under the brand name Phillips' Milk of Magnesia for medicinal usage (Fig. 2).

Did the Milk of Magnesia toothpaste really help smokers get rid of stale breath and stains? Did it really make the teeth clean and get rid of the woolly feeling in the mouth due to smoking? Did the woolly feeling in the mouth mean plaque? How would an antacid toothpaste help clean the mouth? All these questions are difficult to answer but this advertisement makes us think about the evolution and advances in oral care products.

Preena Sidhu, SEGi University, Malaysia
Swapnil Shankargouda, India
DOI: 10.1038/sj.bdj.2014.764

Spit don't rinse

Sir, in Laura Pacey's interview with Tim Elmer on page 13 of the 11 July 2014 issue of the *BDJ* (**217:** 12-14), he says 'including active oral health promotion for recruits, brush twice a day; spit, don't rinse, etc'. I am curious to know where this new advice about not rinsing out after brushing your teeth with a fluoride toothpaste is coming from. I haven't been able to find it on any of the toothpaste boxes that I have checked and I can easily imagine that this might be because – if my memory serves me correctly – one of the toothpaste manufacturers had to make a substantial legal payout to a girl in the United States some years ago because she had damaged her teeth, or her health, by doing exactly this – not rinsing out after she had brushed her teeth.

If this is the case, if somebody in the UK makes a similar claim and it can be shown that they were not rinsing out as a result of advice given to them by their dentist what will the situation be?

J. Hartley
DOI: 10.1038/sj.bdj.2014.765

NHS DENTISTRY

Failed appointments

Sir, since the introduction of the nGDS contract, dentists have been prohibited from charging patients for failed NHS dental appointments. In an effort to gauge the current opinions of colleagues on this matter, a poll was conducted on a UK dental discussion group.

The first question sought to determine the level of support for reintroducing patient charges: 2% (n = 1) of voting members were against failed appointment charges; 77% (n = 50) for all such appointments being chargeable and 22% (n = 14) that charging should be limited to a specified range of unacceptable reasons/excuses. Question 2 asked who should set failed appointment charges if permitted by the NHS: 37% (n = 23) believed NHS, 55% (n = 34) the provider and 8% (n = 5) the performer. Question 3 addressed the division of any fees collected: 20% (n = 12) provider should retain all fees collected, 10% (n = 6) performer should receive all fees and 70% (n = 43) splitting of fees between provider and performer. The fourth question asked if the voter or their practice stopped offering appointments following a maximum of two failed appointments and approximately two thirds were adopting such policies.

In 2011, the BDA reported research which it had conducted into failed dental appointments.[1] It found that failure to attend rates were high, particularly in predominantly NHS practices. In those

INSPECTION ANOMALY

Sir, in March I asked the Care Quality Commission (CQC) what their programme for inspection of clinical dental technicians (CDTs) who work independently is. After a long and convoluted correspondence I have learnt that CDTs do not fall within CQC's remit.

The principal reason for this is that CDTs are not listed within the Health and Social Care Act 2008. A second issue could arise in future because care workers only need to register if they are considered to conduct treatment of disease, disorder or injury (TDDI) as defined in Schedule 1 of the Regulated Activities Regulations. Basically this means invasive procedures. Interestingly, dental technicians are listed under the Act but if they conducted TDDI they would be acting illegally.

I understand that CQC have pressed the Department of Health to deal with these anomalies, but even then, unless the work of CDTs is deemed sufficiently invasive for them to register and then be liable for inspection they will continue not to be inspected. Arguably this is not in the interest of patients, CDTs or our profession as CDTs are becoming a respected arm of the dental profession.[1]

Clearly the Government needs to address this issue urgently.

R. Clark

1. Leyssen W, Clark R K F, Gallagher J E, Radford D R. Developing professional status: an investigation into the working patterns, working relationships and vision for the future of UK clinical dental technicians. *Br Dent J* 2013; **214:** E3.

DOI: 10.1038/sj.bdj.2014.768

practices which derived 50% or more of their income from the NHS, failed attendances accounted for an average of 81 hours of lost time per full-time-equivalent dentist per annum, and 69 hours per dentist in practices with lower NHS commitments. Furthermore, many dentists reported an increase in the number of patients failing to attend appointments since the prohibition on such charges.

However, a note of caution needs to be sounded as the re-introduction of charges may have associated costs and adverse outcomes, including reductions in patient goodwill, related complaints, counter claims for compensation by patients kept waiting and precipitating legal claims for perceived failures of care. Also any policy which is insensitive to the personal circumstances which precipitated the failure to attend (eg illness, personal stressors, factors beyond the control of the patient, dental phobias, etc) is likely to be viewed negatively by both patients and regulators.

One further factor the profession must consider is the political pressure on politicians as they are probably more likely to lose votes by supporting such charges than gain them. The profession, therefore, appears to be in a Catch 22 situation on this issue. It seems likely that only a clear, judicious and fair charging policy is likely to receive qualified support from all the stakeholders.

P. V. Mc Crory, Stockport
A. V. Jacobs, Bury

1. British Dental Association. *Failure to attend.* Available at: http://www.bda.org/dentists/policy-campaigns/research/workforce-finance/gp/FTA-research.aspx (accessed August 2014).

DOI: 10.1038/sj.bdj.2014.766

Dentolegal hot potato

Sir, the new contract in 2006 brought with it the 'UDA' which has been highly criticised and commented on. However, a greater problem was the removal of the guidance on the type of treatment to be offered on the NHS. We moved from one extreme of a very prescribed list with 'items of service' to the other extreme of a completely open-ended contract where it was up to the individual dentist to decide what was 'clinically appropriate' and which treatment modalities would be offered on the NHS.

Dentists have had to act as the 'judges' in what is clinically appropriate and cost effective for the NHS. In medicine these controversial decisions can be left to a third party and then funding allocated appropriately. In dentistry, the lack of a clear boundary or limit to NHS services has left us in a situation in which if we decide a treatment using a certain material or equipment is too costly to offer on the NHS we are advised that it is unethical to then offer that same material or treatment modality privately, take the example of rotary endodontics.

When going through treatment options, the dentist is holding a dentolegal hot potato when they start mentioning technologies that are available privately but not on the NHS. A trend is emerging in NHS practices where the clinician is taking the 'safe option' and only offering the NHS option at their practice. Any items which simply can't be completed with the 1990s tools and materials we still use get referred on to specialists or fully private dentists.

Recently, I went to a CPD session on advancements in endodontics and the use of cone beam CT. The sad fact is that without provisions in the new contract for new (more expensive) technologies to be commissioned and whilst a cheaper option to 'secure oral health' still exists, new technologies will not be adopted as part of the NHS. But without clear guidance on the 'scope' of NHS dentistry it is also preventing a dentist from offering the treatment privately at the same practice and hence limits patient choice.

Current and future versions of the contract still leave it to the dentist to individually make the decisions which commissioners are too afraid to make themselves. It is unfair to put the dentist in that position. This means that difficult decisions are coming directly from the person who both treats you *and* collects your dental charge, leading to mistrust in the profession which holds us back even further.

In the recent Westminster Health Forum 'Dentistry 2014',[1] it was mentioned that dentists with enhanced skills are actually just 'dentists'. I would like to go further and state that dentists with 'enhanced skills' are actually just dentists 'with modern day tools and materials'.

A. Ahmad, West Sussex

1. Dentistry 2014: commissioning, regulation and the dental contract. More information online at: http://www.westminsterforumprojects.co.uk/forums/showpublications.php?pid=761 (accessed July 2014).

DOI: 10.1038/sj.bdj.2014.767

RESTORATIVE DENTISTRY

Tin foil filling

Sir, a former prisoner came to our clinic. According to the patient, he had been imprisoned and was released five months ago. While being in jail, more than seven months ago, he 'suffered from toothache and he also found a cavity in his tooth'. As he was denied access to dental assistance, he manufactured a self-made tooth filling using toothpaste and tin foil. In fact, he constructed a Class I inlay for tooth #37!

He explained that, at first, he folded a piece of tin foil so that it could match the shape of the cavity. Then, he applied a layer of toothpaste to the cavity and afterwards he placed the tin foil inlay. Finally, he applied slight pressure and thus condensed the materials and also shaped the occlusal surface.