LETTERS TO THE EDITOR

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WHAT ABOUT AUSTERITY?

Sir, I am a dentist working in the salaried service (PDS) and am extremely concerned about the level of proposed increase in the annual retention fee.

In the salaried service, we have had pay increases of around 1% per annum, ie from 2010 till the present, a total of approximately 5%. The Government has stated that this is to reflect current austerity measures, and has also stated that there is unlikely to be any increase in this over the next few years.

Nevertheless, the GDC wishes to increase the ARF by 64% – compare that to 5%! Has the GDC not heard of austerity?

It is somewhat disingenuous to try to mollify the effects of this increase by stating that it is tax allowable.

While I understand that the costs of running the GDC have increased dramatically, this has not happened suddenly and must have been recognised over the last few years. Why have increases not been applied over the period since 2010?

Presumably much of the increase relates to the cost of travel and accommodation. Why has more use not been made of facilities available due to information technology, teleconferencing etc?

Surely it is time for the GDC to become more accountable to the registrants?

I hope that this will be brought to the attention of the Chairman, Mr Moyes, and my comments considered.

J. S. Pairman, by email

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PHARMACOLOGY

New therapies and challenges

Sir, among new drugs impacting on oral healthcare are a range of molecules designed to inhibit the growth or effects of tumours. Thus agents with the acronyms BP, RANK and VEGF are becoming increasingly commonplace in clinical practice and all may be associated with a risk of developing osteonecrosis of the jaws (ONJ) – a conundrum for all in oral health care. ONJ is a particular issue following invasive dental or oral surgery, since many such procedures impact on bone.

Bisphosphonates (BPs) are potent inhibitors of osteoclast-mediated bone resorption, which is increased when cancers invade bone. BPs are an established treatment for cancer spread to bone, and effectively reduce pain and other skeletal-related events. Denosumab is a fully human monoclonal antibody with high affinity and specificity for Receptor Activator of Nuclear factor-Kappa B Ligand (RANKL), a cytokine that is the main final mediator of osteoclastic bone resorption.

Angiogenesis inhibitors block various steps in the binding of signalling molecules, such as vascular endothelial growth factor (VEGF), to receptors on endothelial cells to prevent the formation of new blood vessels; molecules such as bevacizumab, sorafenib and sunitinib are used clinically to stop or slow tumour growth or spread.

ONJ may develop in patients exposed to anti-resorptive (BPs, denosumab) and anti-angiogenic (bevacizumab, sunitinib) drug therapy and, although to date there are no documented cases with other anti-angiogenics (eg sorafenib, sirolimus), there may be a potential risk.[1]

The risk of ONJ is about 1% for cancer patients receiving intravenous BPs (zolendronate), and there is a comparable figure for cancer patients exposed to denosumab while the risk for patients on VEGF inhibitors is lower (eg 0.2% with bevacizumab).[2,3] There appears to be an increased risk in those patients on combination anti-resorptive and anti-angiogenic therapy – ONJ may be as frequent as 10% in those on combined BP and sunitinib therapy.[4]

For patients with exposure to the above agents and in whom surgical intervention is required, cessation or interruption of anti-resorptive and anti-angiogenic medication (a drug-holiday) has been advocated to minimise the risk of developing ONJ. However, robust data on the effectiveness of drug holidays are lacking and this has been a controversial topic. A recent AAOMS position paper now suggests that for those who have been exposed to more than four years of oral BPs therapy and for whom a surgical intervention is planned, a drug-holiday of about two months prior to surgery and three months following surgery be undertaken to reduce the risk of ONJ.[5] This paper makes no recommendation for patients on other agents but we suggest, based on the pharmacology of denosumab, that a drug interruption of six months would possibly reduce the risk of ONJ. For VEGF inhibitors, recommendations in the medical literature and adopted by surgical oncologists and plastic surgeons, to minimise wound healing impairment, might be used as a guide: bevacizumab has a median half-life of about 20 days (range 11-50 days) and on this basis they have advocated a 6-8 week interruption of bevacizumab treatment before surgery and four weeks after surgery, to lower the risk of wound complications. Sunitinib has an elimination half-life of 40-60 hours: expert opinion has suggested cessation of sunitinib therapy one week before surgery, restarting after wound healing has commenced at a minimum of one week following surgery.[6-8]

A. Robinson, Singapore
C. Scully, London

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DENTAL PATIENTS

A terrible disservice

Sir, time was when all health professionals had one thing in common – patients. Back in 2006 one NHS Trust ordered staff not to refer to people receiving medical care as patients but as clients. Was this the beginning of the change highlighted in your timely editorial (*Patients are a virtue*; **217:** 53)?

Now even our regulators are referring to those who use our services as customers, not only demonstrating a misunderstanding of our roles but also devaluing both practitioners and those that we care for. Patients are not simply clients or users of health services. Patients are those receiving care, who are given time, are listened to and treated with sympathy, understanding and expertise. There is something special about the term 'patient', and although to give a precise definition is difficult, it is well understood by those who deliver the care.

We, like all health professionals, are not simply service providers and those who describe us as such do us and the patients that we care for a terrible disservice.

G. Feaver, New Malden

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Mafia regulation

Sir, thank you for your editorial of 25 July 2014 regarding the rebranding of 'patients' as 'customers' (**217:** 53).

This is part of the inappropriate application of the world of commerce to healthcare, also evident in the NHS Friends and Family Test which will soon be mandatory in all NHS dental practices.

NHS healthcare in particular – where people are being treated not because they want to be, but because they are suffering from an affliction that they did not desire – is not the place to be judging outcomes by the standards of the supermarket. People who suffer and want that suffering to be relieved are not customers, clients, or consumers. They are patients!

I note with some regret that registrants are now 'customers' of the GDC (if you want to make a complaint about them on the website at least!). The *OED* defines a customer as 'A person who buys goods or services from a shop or business' which definition might just fit our patients, but certainly does not fit registrants of the GDC.

Indeed the GDC is more like the Mafia – providing no goods nor services to its 'customers', but demanding increasing amounts money just to allow them to work in a job for which they are trained. And woe betide you if you don't pay up!

Like many others I welcome the recent BDA stance against the increasingly out of touch GDC and the unprecedented increase proposed for the ARF. Our Association should also make a stand against the inappropriate application of commercial terms and practices to healthcare.

C. J. Rushforth, Bath

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Changing nomenclature

Sir, your editorial *Patients are a virtue* (*BDJ* 2014; **217:** 53) astutely assesses the changing nomenclature, and more importantly, the changing attitude of the treatment philosophy of the dental profession. Here in North America, patients are described as 'clients', and the conduct of a dental practice is a business. In fact, dental practitioners are business persons who happen to possess a dental licence. Their treatment protocol is based upon the ability of their 'clients', or more often, the client's dental insurance company, to pay for treatment required. Advertising of dental services is rife, and has immeasurably lowered the prestige of the profession in public opinion. The professed altruism of patient healthcare is unfortunately too often a secondary consideration.

G. H. Sperber, Edmonton, Canada

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Bah humbug

Sir, a person (no ageism, racism or sexism implied) is involved in a road traffic accident and suffers severe lower body injuries. The paramedics who scrape them off the tarmac and do immediate lifesaving procedures are regulated by the Health & Care Professions Council. The HCPC's role: 'Regulating health, psychological and social work professionals.' The doctors who treat them in hospital are regulated by the General Medical Council. The GMC's mission statement: 'Regulating doctors, ensuring good medical practice.'

These good souls are helped and the patient's well-being aided by nurses who are responsible to the Nursing & Midwifery Council. The NMC's role: 'To safeguard the public by ensuring nurses and midwives consistently deliver high quality healthcare.' There is also input from more members of the HCPC group eg radiographers, physios.

Drugs, etc are provided by the pharmacists who are regulated by the General Pharmaceutical Council. The role of the GPC: 'Upholding standards and public trust in pharmacy.'

After a year they leave the hospital and eventually decide they need a dental examination and maybe a scale and polish. *Now* they need protecting? In the words of Ebenezer Scrooge: 'Bah, humbug.'

A. Caen
By email

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