LETTERS TO THE EDITOR

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SHORT-TERM ORTHODONTICS

Simple protectionism

Sir, I write in response to R. Chate's Opinion article and follow-up letter[1,2] and would like to invite him to an Inman Aligner programme to understand the differences between 'Clear Aligners' and the Inman Aligner as patently it seems he has no idea of how cases are prescribed, set up and planned, or how the system actually works.

These pieces have unfairly lumped all short-term orthodontic treatment (STO) systems into one when there are very clear differences of which he does not seem aware. For example, he states: '*In essence, short-term orthodontic treatments that reposition anterior teeth to facilitate their minimally invasive aesthetic restoration must involve inter-canine expansion and incisor proclination, both of which are inherently unstable orthodontic movements.*' This is completely false in the case of Inman Aligners and demonstrates a lack of understanding of the treatment modality, planning with arch evaluation, use of 3D printing in diagnosis, appliance build and case execution.

To then link Inman Aligners and Clear Aligners and imply that somehow a rise in complaints of 'aligners' could be attributed to Inman Aligners without any direct evidence, or any real idea of the actual numbers of STO cases carried out in the UK to compare any rise to, is in my opinion highly suspect. The cynical side of me feels that that both pieces simply smack of simple protectionism. If equally vociferous articles or letters were forthcoming during the years where thousands of patients had crooked teeth prepared for veneers instead of having orthodontics, I might feel differently. I sincerely hope I am wrong and hope to enlighten him on this particular modality of treatment. Despite the above comments, the invitation is warmly offered.

T. Qureshi, by email

1. Chate R A C. Truth or consequences: the potential implications of short-term cosmetic orthodontics for general dental practitioners. *Br Dent J* 2013; **215:** 551–553.
2. Chate R A C. Short-term orthodontics: high profitability and low risk. *Br Dent J* 2014; **217:** 107.

R. A. C. Chate responds: Like many protagonists of short-term cosmetic orthodontics, Mr Qureshi has incorrectly presumed that in its published comments on this topic, the Faculty of Dental Surgery of The Royal College of Surgeons of Edinburgh has acted in order to either protect conventional orthodontists or to have short-term orthodontics as a potential treatment option be withdrawn from clinical practice.

In his listed references to the Faculty's previous publications he has clearly missed the one in relation to the point/counter-point debate between Mr Maini and myself, in which the above two myths are dispelled.[1]

Mr Qureshi claims I have unfairly lumped all short-term cosmetic orthodontic treatment modalities together and in relation to the Faculty's previous statement that 'short-term orthodontic treatments that reposition anterior teeth to facilitate their minimally invasive aesthetic restoration must involve inter-canine expansion and incisor proclination, both of which are inherently unstable orthodontic movements'[2] *he states this is completely false in the case of Inman Aligner therapy.*

He believes I lack an understanding of his treatment modality and extends an invitation to attend one of his training courses.

I have reviewed the Inman Aligner website for further details and was interested to read the pages on 'Results', 'Case of the month' and 'How it works.'[3]

From these it is clear the modus operandi of Inman Aligners involves straightening irregular anterior teeth through opposing labio-lingual, removable appliance tipping pressures and all of the cases that have been illustrated have not involved the

NASTY NATIONALISTS

Sir, C. Jones' opinion piece[1] requires some expansion: 'typically' credit is given to the government-sponsored Childsmile programme for the measured increases in numbers of decay-free children in Scotland. However, 'typically' is not evidence and this seems to be lacking. The figures quoted reflect a continuing trend over a longer period. We could just as easily say that 'typically Scotland has only been catching up on trends that have already been occurring elsewhere in the UK'. Governments like to claim credit for things as a result of their actions/initiatives – whereas in reality they are usually behind the times when it comes to changes in people's behaviour. One only needs to look at the massive increases in use of trains and bicycles over recent years to see that this is so – governments are only now starting to respond to long-running changes in behaviour.

Controversially, the most effective way to get people to change their habits is hit them in the pocket (not by tax but by getting them to pay for the damaging effects of their existing habits) – in this respect Stephen Hancocks' editorial in the subsequent *BDJ* comes as a breath of fresh air.[2]

More controversially, the reported 'levers' to affect Public Health policy appear to be a return to the 'nanny' state – where those in power enforce measures 'for your own good'. Measures that sound increasingly repressive and wasteful in effect (how much salad would be wasted if it were served not as an 'offer', but as an 'obligation'?). It is clear that, as we survey the current world scene, nationalists are everywhere: Syria, Russia, Holland, Hungary – even France. Everywhere they have the same ugly face and evil policy: the pursuit of national greatness above *all* else.

Nationalists are the same animal everywhere, irrespective of the adjective put in front: they are nasty people. Scotland is no exception.

Y. Maidment
Edinburgh

1. Jones C M. Independence and oral health: implications of the Scottish referendum. *Br Dent J* 2014; **217:** 65–66.
2. Hancocks S. Oh sugar! *Br Dent J* 2014; **217:** 105.

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extraction of any teeth.

As such, the only way Inman Aligners can create additional space to straighten crowded teeth is either through arch width expansion, incisor proclination, interproximal enamel reduction or a mixture of any or all the above.

Therefore, it is unsurprising that the final bullet point on the web page of 'How it works' states, '...retention is recommended for life to prevent relapse. Retention can come in the form of a lingually bonded retainer or an Essix retainer.'[3]

However, no mention is made about the potential long-term failure rates of either of the above retainer systems nor, as a consequence, what the biological and financial consequences might be for a patient who subsequently experiences rapid relapse after a course of short-term cosmetic orthodontic treatment, both of which the Faculty, in its original guidance publication, has suggested should be essential informed consent patient information.[2]

In relation to Mr Qureshi's criticism that the published data from Dental Protection are insufficiently refined to differentiate between the claims made against the different short-term cosmetic orthodontic treatment systems, the data are irrefutable.

Irrespective of whichever treatment system is used, they all align irregular teeth in a similar way and as such, carry the same risks and consequences.

Finally, it is interesting to note that Mr Qureshi has declined to comment on the Faculty's concerns in relation to what has been suggested general dental practitioners should charge when using short-term cosmetic orthodontic appliances, including Inman Aligners.

Since many might regard such fees as exorbitant, his silence is revealing.

1. *Maini A versus Chate R A C. Short term orthodontics debate.* Br Dent J *2014;* **216:** *386–389.*
2. *Chate R A C. Truth or consequences: the potential implications of short-term cosmetic orthodontics for the general dental practitioner.* Br Dent J *2013;* **215:** *551–553.*
3. *Inman Aligner website. http://www.inmanaligner.com*

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FITNESS TO PRACTISE

Harrowing reading

Sir, S. Ward is to be congratulated on having the courage to give us an account of the GDC's Fitness to practise process (**217:** 162). It made for harrowing reading. He/she had acted entirely professionally but had had the misfortune to encounter a patient who wanted to cause this dentist trouble with no risk of consequences to him/herself, an encounter which many of us will sadly have had.

Two years of GDC-induced insomnia later, the GDC finally realises 'that the complainant had refused to provide a witness statement' and dropped the case. Sitting as a magistrate, my colleagues and I are able to award costs against the prosecution when a trial collapses for this reason. Perhaps it is time for the GDC to pay compensation for distress, loss of earnings and wasted costs to S. Ward and the defence society which had spent £15,000-£20,000 on preparing the case. By doing so they would become accountable for their mismanagement and would hopefully be more cautious in whom they tried throwing the book at.

The GDC's refusal to inform this dentist's employer of the 'no case to answer' outcome is shameful and risks an unjustified blot staining this dentist's reputation. From this sordid matter, nobody won, not even the complainant, and yet many people lost a lot of sleep and money.

There was an alternative route which the GDC should have chosen to take which would have resolved the whole process within a few weeks and at a fraction of the financial and emotional costs to all concerned. The GDC funds, but is separate from, the Dental Complaints Service (DCS), of which I am a dentist panellist. Had the matter been referred to the DCS, the DCS would have got both sides to talk and would have discovered very quickly that the patient was not prepared to substantiate the claim and the matter could have been closed then. S. Ward would have been able to get on with stress-reduced work, his/her employer would not have needed to know and the defence society would have been spared the costs. Meanwhile, the patient would have been unmasked as a malicious trouble-maker at the earliest possible opportunity, thereby ending this whole sordid episode in the dentist's life, both quickly and efficiently.

I implore the dental profession, and the GDC, to embrace the highly cost-efficient facility which the DCS offers to investigate complaints and to resolve conflict.

Talking of financial costs, we know how much the defence society honourably used from our subscriptions for this single case and one can only imagine with horror the amount spent by the GDC from our annual retention fees. What a complete waste of so much money which they collect from us and which we charge to our patients.

C. Marks, Southampton

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