COMMENT

Letters to the editor

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Orthodontics

Unacceptable scaremongering

Sir, I remain very concerned that Nicky Stanford continues his misleading and scaremongering tactics, including through the letters of the *BDJ*.[1] He knows full well that the Advertising Standard Authority (ASA) refuse to even consider the proper best practice evidence-based medicine (EBM) criteria in their deliberations. The ASA will now only consider very clear orthodontic results from randomised clinical trials (RCTs) – it means nothing to the ASA even if one has a hundred consecutive good fast ortho cases as a clinician; no RCTs = no claims/possibilities are now allowed to benefit others on informative websites or adverts, basically.

That is very narrow and punitive ASA criteria for those clinicians achieving great clinical results on a very regular EBM basis. It could now mean almost all 'current practice' claims/possibilities in dentistry may not be made publicly, including orthodontics improving intra-oral health, at all. So ironically Nicky Stanford (and his small group of co-conspirators?) may well be making a bigger rod for their own UK orthodontic colleagues' backs.[2]

I also note straight after his 11 March 2016 BDJ letter was published[3] it was critiqued heavily upon social media in the following days. Nicky Stanford only then sets out looking for other victims many weeks after this, prosecuting his campaign again and complaining afresh to the ASA on 23 April 2016.[4] Thus there was no overlap of his ASA complaints/outcomes and his 2017 excuse for not responding/apologising for his original misleading and scaremongering tactics in 2016, just compound errors and now looks manipulative, vindictive or potentially abusive.[5]

A non-academic may not know what EBM multiple-criteria actually are (best practice), but to mislead *BDJ* readers without making this aspect clear, then scaremongering with partial information and implied threats to registrants, is simply unacceptable.[3] Nicky Stanford now owes myself, our profession and readers of the *BDJ* a double-apology after a double-dose of reflection, otherwise he is in danger of remaining double-blind vengefully, I fear.

T. Kilcoyne, by email

1. Stanford N. Orthodontics: Falling foul of standards. *Br Dent J* 2017; **222:** 498.
2. Millett D T, Cunningham S J, O'Brien K D, Benson P, Williams A, de Oliveira C M. Orthodontic treatment for deep bite and retroclined upper front teeth in children. *Cochrane Database Syst Rev* 2006; CD005972.
3. Stanford N. Orthodontics: Fast removal of claims. *Br Dent J* 2016; **220:** 220.
4. ASA Ruling on IGDP Ltd. 8 March 2017. Available at: http://www.asa.org.uk/rulings/igdp-ltd-a16-348854.html (accessed 15 May 2017).
5. Kilcoyne T. Orthodontics: monopolistic behaviours. *Br Dent J* 2016; **220**: 558.

DOI: 10.1038/sj.bdj.2017.430

Referrals

We must work together

Sir, regarding Mr Raftery's letter,[1] the British Association of Oral Surgeons (BAOS) share the author's concerns regarding provision of potentially substandard apicectomies and we agree that in an ideal world all these procedures should follow the national guidelines. The guidelines for this procedure by RCSEng (which our president, Professor Renton, was involved in writing) demonstrate the importance magnification and ultrasonic preparation have in achieving higher success rates. We are disappointed to learn some of Mr Raftery's local colleagues do not have access to the equipment required to comply with guidelines.

Periapical surgery appears on the specialist training curriculum of both oral surgery and endodontics and indeed, many of our oral surgery trainees undertake this training with guidance from both oral surgeons and endodontists in a hospital setting. We of course agree that in line with recommendations for commissioning of dentistry, the procedure should be completed in the most appropriate setting, by the professional with the required skill set and at best value for money.

Unfortunately, the reality is that many patients are not able to access routine RCT and trends in NHS dentistry demonstrate a reduction in complex treatments, such as root canal treatments (45% according to Health Committee Enquiry), and an increase in extractions, since the introduction of the contract in April 2006. As we're sure Mr Raftery agrees, we must work together to achieve the best possible outcomes for patients using the available evidence in the environment of the National Health Service and within the remit of both specialties. Hopefully, the future will provide access for all NHS patients to evolving endodontic therapies, thus reducing the need for RCT and subsequent periapical surgery and unnecessary extractions.

S. McKernon, by email

1. Raftery P. Referrals: Apicectomy. *Br Dent J* 2017; **222:** 2.

DOI: 10.1038/sj.bdj.2017.431

Dental practice

Deep satisfaction

Sir, I enjoyed 'First impressions':[1] it never does any harm to put yourself in your patients' shoes. But I was reminded of the time I was lolling on a popular beach in Corfu when a couple of larrikins on mopeds turned up. One of them yelled, 'Oi, SPIRO!' About half of the men on the beach jumped up and looked around while the pair made their escape bent double with laughter.

Where I currently work, if I went into the waiting room and asked for Mr Macdonald

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about half of the men would get to their feet. We have to ask by first and second name and even then sometimes have to fall back on nicknames. This is a rather special corner of Paradise in the Western Isles where we have a 12-surgery Health Board clinic (Western Isles Dental Centre). My colleagues are enthusiastic and funny, and compassionate. The patients have, to a large extent, retained a rather old-fashioned respect for professional people. They are understanding when we run late and appreciate the fact that we all try hard to provide a good service. Practising dentistry here is deeply satisfying.

N. Cole, by email

1. Coe J. First impressions. Meeting and greeting in the clinical setting – are we doing what patients want? *Br Dent J* 2017; **222:** 511.

DOI: 10.1038/sj.bdj.2017.432

OMFS

Mishandled Luxators

Sir, we read with interest Dr Shuttleworth's reflective letter on his surgical practice and the origins of the Luxator.[1] The same week the head nurse in our department brought to our attention six damaged Luxators returned by the sterile services department (Fig. 1).

Clearly these instruments have been abused and used as elevators with significant damage to the instruments in a relatively short time. This has prompted us to review the use of Luxators in our department. The vast majority of routine oral surgery/exodontia procedures has been and can be safely and effectively carried out with the additional use of conventional elevators. This can be in the form of Warwick James, Coupland's chisels and Cryer's elevators, which are routinely available in the MOS sets.

The senior author after three decades in oral surgery has adopted the use of Luxators in the last year for flapless atraumatic extractions preparatory for immediate implant placement. Luxators may be suitable for select cases of fractured roots or apices used carefully under direct vision and in a controlled and careful manner.

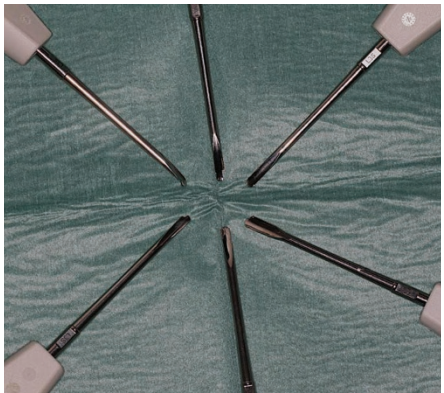

Fig. 1 Damaged mishandled Luxators

We would like to emphasise the cautious use of these sharp instruments as an adjunct in select MOS cases. It is advisable to use them with minimal pressure and appropriate finger rests to avoid any tissue damage when being applied in the periodontal space in case the instrument slips.

P. Parmar, A. Majumdar,
Beds Herts and Bucks Maxillofacial Network

1. Shuttleworth J. OMFS: My favourite instrument. *Br Dent J* 2017; **222:** 322.

DOI: 10.1038/sj.bdj.2017.433

Dental education

Reflective practitioners

Sir, as a current dental foundation trainee I was disappointed to read the article which expressed concern with 'declining standards' of trainees.[1] Although it may be true that we have had less clinical experience than our historical counterparts, I found it short-sighted that this was the only focus.

In this changing day of dentistry, and with the introduction of revalidation, the clinical component is only one of the four key domains. I feel that we are amid a new generation of dentists, and I do not agree that we are 'medico-legal centric', but rather we are focussed on developing in all four components for the benefit of our patients. Although some foundation trainees may have less experience with clinical procedures, the article failed to discuss other aspects key to foundation training. For example, in my training scheme we have received excellent feedback from our patient satisfaction questionnaires, completed multiple audits, and can self-identify our individual learning needs and create a personal development plan accordingly. It may also be valid to consider that clinical proficiency in a treatment such as crown and bridgework can be gained through experience in the general practice setting, whereas effective patient communication is a vital skill to acquire at the start of our careers. These other aspects contribute to us becoming well-rounded professionals and improve the standards of care for our patients. Overall, although I appreciate that the findings from this study do indicate a possible need to review undergraduate training, I think it is important to remember that clinical skill is only a quarter of the overall picture. I believe as current dental trainees we are developing into reflective practitioners and this is something that should be celebrated.

G. Kane, by email

1. Oxley C J, Dennick R, Batchelor P. The standard of newly qualified graduates – foundation trainer perceptions. *Br Dent J* 2017; **222:** 391–395.

DOI: 10.1038/sj.bdj.2017.434

Negative tone

Sir, the paper by Oxley, Dennick and Batchelor[1] presents our profession with some potentially challenging findings. Despite the limitations of this research, including how 'standards' were defined and any potential bias related to the poor return rate, we were disappointed by the negative tone of the discussion. Surely as a profession we should be delighted that so many of our new graduates are patient focused with good communication skills, with an emphasis on health prevention and professionalism.

As we educate final year students in an NHS primary care outreach setting, we are only just the other side of the divide between pre-qualification and foundation training. We have reported previously that students feel prepared for the challenges of qualification, NHS practice and DFT.[2] At the University of Portsmouth Dental Academy we do encourage the more advanced clinical skills of endodontics and crown and bridge, but with many patients on red and amber care plans these treatment modalities are often not appropriate to the frustration of both the students and their clinical teachers.

Our 'junior colleagues' need to leave undergraduate dental education after five years. Yes, they could gain more clinical experience, particularly in diagnosis and care planning, with additional time at dental school and in outreach situations, but surely this experience is the rationale for the provision of our well-funded foundation training. It is perhaps ironic, at a time when dental schools are increasingly making use of motivated, enthusiastic, part-time general dental practitioners to teach clinical skills to undergraduates, that a different group of general practitioners, the foundation trainees' educational supervisors, feel that those clinical skills are inadequate. As the educational supervisors are overseen by