Please note that all letters must be typed. Priority will be given to those that are less than 300 words long. All authors must sign the letter, which may be shortened or edited for reasons of space or clarity. All letters received are acknowledged.

Denplan assurance

Sir, — Some time ago, my receptionist received a telephone call late one afternoon from a distraught patient. She had just broken a cusp off an upper first molar. The patient was on her way from Bedford to Stansted Airport where she was booked on a flight to Italy. She was most anxious that she would develop bad toothache while away but she would miss her flight if she returned to Bedford for emergency treatment.

My receptionist reassured her, but as the patient was in Denplan, she also suggested telephoning their helpline. The Denplan operator was equally reassuring. However, she was able to consult a map, call another Denplan practitioner in Sawston, which was nearby, and arrange for emergency care.

My patient was overwhelmed by the extremely efficient and caring service. She said that she felt better immediately when the Denplan operator reassured her that even if there was insufficient time to repair her tooth before departure, she should catch her flight in any event, and call again from Italy.

This proved unnecessary because the lady practitioner in Sawston restored the missing cusp very neatly with glass ionomer cement and the patient enjoyed her holiday to the full.

Stephen Noar founded Denplan based on very sound ideals. He was dissatisfied with the available services and knew that he could provide a better system for both patients and practitioners. I am very reassured that despite the change in ownership of Denplan, they do not seem to have lost the original 'vision' of Stephen Noar.

E Byrne
Bedford

Fast track consult

Sir, — I wish to comment on the article 'Direct referral day case oral surgery for dental practitioners: a pilot investigation' (*BDJ* 1999; **186:** 334-337) by T Renton and M McGurk.

I have been in a practice limited to oral surgery since October 1991. With my knowledge of the 'tradition' in the hospital, ie referral letter sent by the patients dental surgeon, appointment for consultation, waiting list and eventually date for surgery (multiple visit group 3), I adopted the 'single visit' approach (direct access for consultation and treatment, if indicated, at the same visit). The advantages of the 'single visit' are obvious for all to see.

Unfortunately, in the 'High Street' set up, where patients may have to pay for their surgery'[1] — the single visit approach — this can create and has created problems. I therefore introduced the 'double visit fast track consult' alongside the former. The latter gives the patient the opportunity to consider the treatment planned, the cost, prognosis and material risk as well as the alternatives to the planned surgery.

Such an approach as outlined (either the single or double visit) requires the co-operation of the referring dentists and also an experienced and competent surgeon.

S Appiah-Anane
Liverpool

Reference
1 General Dental Council. Maintaining Standards: guidance to dentist on professional personal conduct. London: General Dental Council, 1997 (revised November 1998).

Statutory registration for dental nurses

Sir, — I read with interest the letter from Dr R Longhurst (*BDJ* 1999; **186:** 212) on statutory registration for dental nurses. Having been involved in the broader field of dental education for many years within processes in a teaching institution (The Maurice Wohl Centre at King's College) the private sector (BUPA), my personal private practice and now on a freelance basis, there was much in this letter on which I would like to comment.

I am not entirely convinced that it was written out of concern for the situation of dental nurses in general, should statutory registration become an obligation. Rather it appears as reflecting a singular dentist's concern in maintaining the *status quo*. The statement referring to not obtaining the National Certificate that it 'has not meant that with in surgery training by myself that they would not be excellent employees" is the nub. They (*ie* the nurses) certainly, it seems, would suit the individual practitioner's needs, but how would they stand if a career move was envisaged offering advancement and possibly a better remunerated position?

The Nuffield report[1] — rightly in my opinion — highlighted the anomalies and deficiencies of training pathways for dental nurses, and the countrywide lack of consistency in training (if any). The cake shop on Friday afternoon and front line at the chairside on Monday morning with a badge that says 'dental nurse' and its implication to patients that this person at least knows something about the environment into which she (sometimes he) has been thrust is not uncommon. Is there one surgeon operating in a hospital theatre in the UK whose nursing assistant comes from a Job Centre?

Put in another way, among other fields of training outwith healthcare, where teamwork is the essential element to achieve most effective delivery of skills and to safeguard quality and consistency, an example could be the flight deck of an airliner. Who in their senses would consider that the most appropriate way to train a captain and first officer to undertake all the procedures to effectively and safely fly a Boeing 747 would be to train just the captain to fly a Tiger Moth? A fair comparison to today's dental team training I submit, where the settings in which many student dentists first learn clinical procedures necessitate considerable transfer of skills from pre-clinical phantom head laboratories to various undergraduate clinics, to eventually the work positions and methods used in practice. It is entirely predictable that this will be even to the extent that procedures learned without assistance will routinely be later performed with assistance.

It is dentists — and only dentists — who will eventually change this regrettable situation. The recent DARG document[2] evidences within its contents how the understanding of the benefits of close support integrated operating within the disciplines of dentistry by those who authored this document lags behind the reality.

The potential for a huge elevation of standards in an integrated operating environment where the nurse has an involvement is only guessed at by most dentists who sadly struggle on throughout their whole career span of 40 years or so with the basic skills taught while at dental school, which are dentist focused. The need to allocate appropriate resource and legislation to dental nurse training needs to be matched with a complete review of the mindset of dentists with regard to team delivery of the procedures that make up contemporary safe and effective oral health care.

Otherwise I fear we have come not very far in the last 75 years in this respect. The only major innovation in this time being placing the patient in the supine position, a move still poorly understood and utilised by everyone from equipment manufacturers, some teachers at undergraduate schools through to all levels of the dental team.

It is unfair to all dental nurses to imagine or suggest that anything other than a structured and documented training programme — in practice for the most part — is appropriate. The methods for assessment could

realistically be reviewed and updated perhaps, but the the achievement of statutory registration should be part of this process.

K F Marshall
Oxted

References
1 Education and Training of Personnel Auxiliary to Dentistry. The Nuffield Foundation 1993.
2 Professionals Complementary to Dentistry. Report of the Dental Auxiliary Review Group, General Dental Council 1998.

Measuring nursing competence

Sir, — In a letter regarding statutory registration for dental nurses (*BDJ* 1999; **186:** 212), Dr Longhurst states that 'possession of a certificate does not guarantee that a dental nurse is conscientious or honest or completely trustworthy' — a sentiment with which I concur completely. The same could, of course, be said about a dentist, doctor, general nurse or veterinary nurse, all of whom require qualifications and registration in order to be allowed to practice. Not to indicate their moral worth, but to indicate that they are competent — which, of course, as we are all aware, can only be measured against a given standard. While discussing standards and criteria, may I ask Dr Longhurst how one measures whether a person is 'conscientious, honest, trustworthy' — the three criteria to which Dr Longhurst appears to give more weight than she does to competence?

I believe that the question should not be whether Dr Longhurst's unqualified dental nurses are loyal, hardworking, conscientious etc, but whether they can be proved competent in their dental nursing skills — to a national standard. In fact, implicit in statutory registration is adherence to a professional code of ethics — a fact which Dr Longhurst, as a registered dentist, should be aware of.

Dr Longhurst is correct in assuming that the majority of the general public — or, in other words, patients — questioned in the British Association of Dental Nurses survey (91%) were of the opinion that all dental nurses should be adequately trained, qualified and registered.

Dr Longhurst's concern for those members of staff who 'have been with us for some years but have not attained the National Certificate' is touching, but somewhat ingenuous. No one is suggesting that such members of staff be told 'Sorry, you're not clever enough to work here' as Dr Longhurst suggests. It is anticipated that a grandparent clause will ensure that dental nurses with a specific number of years' experience be allowed to register on the strength of that experience — as indeed were unqualified but experienced dentists in 1921 following the introduction of the Dentists Act.

The British Association of Dental Nurses stand by their statement that 'statutory registration of dental nurses is vital for the protection of the public'. I would be interested to know why Dr Longhurst is so anxious to remain with the *status quo*. What on earth are the disadvantages to anyone concerned — dentists, Professionals Complementary to Dentistry or patients — in having an adequately trained, measurably competent workforce? Fortunately, the GDC, the body responsible for the protection of the patients, agrees with that statement and has voted for the introduction of statutory registration of all the PCDs.

P Swain
Executive Secretary
British Association of Dental Nurses
Fleetwood

Training for nurses in oral care

Sir, — We would like to echo the sentiments of S Boyle who recently wrote to the *British Dental Journal* regarding the lack of training for nurses in oral care (*BDJ* 1999; **186:** 159). Longhurst has highlighted this problem (*BDJ* 1998; **184:** 453-457) and our group has recently conducted a study to compare the oral care knowledge of hospital nurses caring for the elderly and health care assistants in nursing homes.

Our results have shown that there are many deficiencies in oral care knowledge in both groups. Indeed, nearly a fifth of both groups (18%) did not realise that edentulous individuals require regular oral 'checkups' and between 85% and 95% of the staff incorrectly believed that dentures are available 'free' to all pensioners on the NHS.

This subject area is important as demographic changes in society dictate that the oral care of the elderly will, in the future, become an increasingly substantial issue.

A J Preston
M A Gosney
Liverpool

Amalgam bonding

Sir, — In the paper on the resin-bonding of amalgam in the *British Dental Journal* (*BDJ* 1999; **186:** 328-332), the authors do say that their review of current systems and literature is not exhaustive. For this reason I feel I must bring to the notice of *BDJ* readers the paper of M Al-Moayad, Y E Y Aboush and R J Elderton, (*BDJ* 1993; **175:** 363).

This paper describes the use of a 'dual cure' glass ionomer (Vitrebond) for amalgam bonding. In vitro the bond achieved using a simple technique was found to be superior to that obtained with dedicated bonding materials (Amalgambond and Panavia). We experimented with the technique at that time in this practice, and found it to be amazingly successful. Since then I have used Vitrebond as as adhesive interface in the vast majority of amalgam restorations. This allows of a much more conservative cavity preparation for routine fillings, and may avoid the necessity for pin retention in extensive cavities or with cuspal fracture. The material is also used for routine lining so there is no need to invest in a separate, expensive bonding material.

Unfortunately there is no fee for this procedure in the NHS as far as I know, but it is so simple, quick and effective that I commend it to colleagues who have not tried it yet.

J C Budden
Southampton

Mobile phone use

Sir, — I am indebted to your reader P Budden (correspondence *BDJ* 1999 **186:** 369) concerning a possible relationship between dental pain and the use of mobile phones. I also recently treated a patient complaining of the same problem. However, she was able to inform me that discomfort only occurred if she used a mobile phone of the analogue variety but that the digital types were totally pain free.

J Kaufman
London

The Bonnalie Cup

Sir, — Please permit a reference to golf, a mere pastime, but important to many readers.

The West Lancs, West Cheshire and North Wales Branch possess a magnificent golf trophy, the Bonnalie Cup. We wondered if it is the oldest trophy played for by BDA members, as this year it is celebrating its 75th anniversary.

The Branch is marking this event by donating a cup in memory of Squire Brayshaw, whose enthusiasm from the early fifties to the early seventies kept the competition alive.

We would be interested to hear from any relatives of Colonel Bonnalie and Squire Brayshaw who might wish to join us at Southport for this year's event on Thursday, June 17.

Contact number: 0151 652 4579.

J D T Oldham
Birkenhead