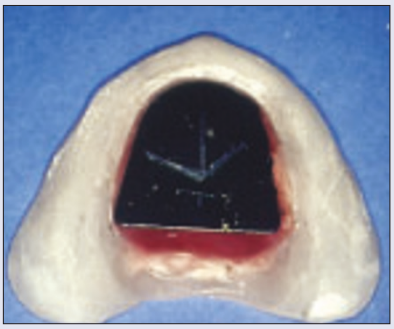
Send your letters to the editor, British Dental Journal, 64 Wimpole Street, London W1G 8YS. E-mail bdj@bda dentistry.org.uk
Priority will be given to letters less than 500 words long. Authors must sign the letter, which may be edited for reasons of space.

Gothic arch tracing

Sir, — The article on occlusion (*BDJ* 2001; **191**: 499) and the reference to the 'Gothic arch' tracing reminds me that I had not heard of this method since an incident at Kings College Hospital Dental School in 1949. As a student, I was allocated an elderly patient who had never been able to afford dentures and who, due to the new National Health Service was now entitled to have them free of charge.

She required full upper and lower dentures and the requisite plaster impressions were taken with a cast metal special tray. Having made the registration blocks and adjusted the screw, the patient was asked to perform the excursions to produce the 'Gothic arch' arrowhead map.

This she duly did and when her arrowhead trace was inspected it came out perfectly. But, to everyone's astonishment it was facing forward and not backward as expected. After several further attempts, I was told to abandon the Gothic arch and resort to other methods.



Gothic arc trace arrowhead

We never did find out why the tracing was reversed but in the end the lady was happy with her new teeth.

What goes around, comes around.

M. Scott, Shrewsbury

Orthodontic specialist lists

Sir,— Paul Cook's guest leader on this subject (BDJ 2001; **191**: 288) is to be welcomed. I may be able to give some additional information about the group of general dentists who applied for inclusion and later, when rejected, decided to appeal.

Levels of expertise are rising all over the world and the British Orthodontic Society (BOS) has been pressing the GDC to recognize specialist orthodontists for some time. With the objective of raising standards, BOS initially felt that only those who had taken a three-year course and gained a Certificate of Completion of Specialist Training (CCST) should be eligible. This would have excluded a large number of dentists who had taken the one-year Diploma course many years previously. However, this was later felt to be restrictive, and subsequently almost all dentists who had taken a diploma in orthodontics, either here or abroad, were included.

This still excluded a large number of general practitioners who held no diploma, some with exclusive orthodontic practises and some with a high proportion of orthodontic patients in their general practises. At that time, spring 1999, these practitioners were exceedingly worried and depressed, a situation not helped by the then Chief Dental Officer hinting that eventually only specialists would be able to provide orthodontics within the Health Service.

As Paul reminds us, this threat was subsequently withdrawn, but the fear remained that future 'purchasers', together with insurance carriers, would tend to favour registered orthodontists, possibly exclusively. It is still possible that the protection societies may at some future date restrict the provision of orthodontics by unregistered practitioners. Some Area Health Authorities have already removed the names of general dentists who provide orthodontic treatment from the lists displayed in libraries, post offices, etc.

I studied the regulations to find that there was a mechanism for general dentists to be registered if they had equivalent experience and expertise (not knowledge) to a student who had just completed a CCST course.

In my opinion many of those who I knew that had been turned down had far more experience than this. Realising that if nothing were done all these individuals would lose their chance, I contacted my colleague Richard Bateman and together we wrote to all members of the specialist orthodontic group and anyone else we thought might be in a similar position.

Unfortunately, the general practitioner group of BOS who must have contained many members in this situation decided not to circulate their members for whom it is now too late. Sadly, it was also *BDJ* policy not to publish letters that were sent to more than one journal so our circular failed to reach a number of those who could have been helped.

After consultation with John Hunt of the BDA,who was very supportive, we met as a group and subsequently decided that anyone who had treated over a hundred referred cases was *ipso facto* already an orthodontic specialist. We then raised a sum of several thousand pounds and took Councils advice, to be delighted that his view concurred with ours. About 60 of our group appealed and all who have had hearings have so far been successful.

I can sympathise with those young orthodontists who had to starve themselves for three years working weekends to make ends meet, only to see general dentists with not much experience being admitted to the specialty but it is not only the law, it is also a humane approach used by many other specialties.

It is nice of Paul to extend his hand to these new recruits because I know the personal pain he has gone through and I would like to support his request for all successful appellants to join the BOS. As he says, 'both the GDC and the SAC would do things differently given the opportunity again'.

Hindsight is a wonderful thing.
J. Mew, Heathfield

Sir,— Paul Cook's postmortem of the Orthodontic Specialist List saga reveals just how strongly opposed he was, and is, to admission to the list of experienced existing specialists.

Admissions via the appeals procedure is a legal loophole and is not 'correct'. It's 'not fair', he is 'aggrieved' at the unfairness of it all. He would 'do things differently given this opportunity again' and in particular would want 'a voice' at the appeal as well as on the original assessment. Fortunately, there is centuries of traditional wisdom in the British legal system that guards against the potential injustice of a veto and excludes the trial judge from a subsequent appeal.

Mr Cook has obviously worked unstintingly in his capacity as Chairman of SAC ,but in view of these personal opinions was he the right person to oversee the original applications? Did the GDC, which itself set up clearly defined parameters for mediated entry in the first place, make a serious mistake in appointing a person so opposed to its intentions?

And while on the subject of the GDC Specialty – Specific Guidelines, how did it come about that they were contravened by the introduction of a requirement to take the MOrth examination, something that was proposed by the previous Chairman of SAC in a BOS Newsletter (Spring '98) but never featured, to my knowledge, in any official GDC document? Those few brave souls who took this difficult option are to be congratulated, whether they passed or not, on the decision to 'test their expertise' as Mr Cook puts it. One wonders how keen to do likewise would be some of those accepted onto the list with orthodontic qualifications obtained say 20 or more years ago.

It appears to me that the GDC failed to act with the strength of its own convictions in these matters, and perhaps Paul Cook should have disqualified himself from the job anyway, on the grounds of his opposition to the principles first laid down. Nevertheless, should my own pending appeal be successful, I will be happy to accept his invitation to join the BOS Specialist Practitioners Group.
M. L. Fennell, Essex

Sir,— I would like, through your pages, to congratulate Paul Cook on his typically thorough article, 'The Specialist List in Orthodontics, a postmortem'.

I noted only one inaccurate statement - the appellant is in fact not the only voice heard at Appeal, the GDC appoint a solicitor who opposes the application and cross examines the appellant as appropriate. As in the conventional legal system, the magistrate that made the original decision would not have a further say in the Appeals court.

Paul is very honest in making his opposition to non-formally trained applicants quite clear. This view seems to be based on the assumption that there is only one way to 'skin a cat', ie, training via the traditional pathway. Many Grandfathers have trained semi-formally, typically with hospital consultants in clinical attachments. Some of the CV's I saw of applicants with over 30 years of experience were awesome.

However, every person who had not completed a formal training course was rejected. The legal position was made quite clear by the GDC - an applicant who could demonstrate having acquired *through experience* the equivalent expertise to that of a newly qualified M.Orth (who might typically have treated a hundred odd cases in three years) should have been accepted onto the Register. This precedent applied to the original Dentists' Act and has been followed in similar professions, eg accountancy and physiotherapy.

When Paul and his committee chose to ignore this directive they did every member of the profession a financial disservice. The successful applicant is generally refunded their £1,000 appeal fee leaving the GDC, ie you and me, to foot the bill. Obviously there was always going to be a cost here but with large numbers of successful applicants who clearly should have been accepted at initial screening, this will run to many tens of thousands of pounds in excess of budget.

The Orthodontic Grandfather Group was set up in 1999 as a small self-help group to encourage the significant number of rejectees and potential rejectees (generally only the very experienced applied initially, so we were quickly aware of the discrimination).

Legal advice supported our view and gave us the confidence to go through the daunting Appeals procedure. Sadly, one or two members became so distressed by the whole experience that they have suffered physical illness, but fortunately many are enjoying life having acquired Specialist status, thanks to the firm but scrupulously fair attitude of the Judge.

I would congratulate Paul on his conciliatory conclusion that we should now all work together. Most of our members are long time BOS members and will continue to support a Unified Society. We hope to wind up our group at the end of the appeals procedure next year,

donating any surplus funds to the Sick Dentists Scheme.

Finally, I would like to further congratulate Dr Cook on his election to the GDC, but perhaps might gently temper that with the respectful suggestion that he might try to avoid personal views conflicting with his legal responsibilities in the important work that lies ahead of him.

R. Bateman, Croydon

Paul Cook responds:

Sir,— I am pleased that my article has generated these responses and I am also grateful for the respectful tone of two of them. I, too, respect the views of those on 'the other side of the fence' to myself, but would not wish to prolong what has already been an overlong affair. I have been aware that we may have just about got it right as, over the last three years, I have received flak from both sides. I hope the exercise can be completed soon and we can all move forward together as a unified specialty.

Removable appliances

Sir,— Re: The role of removable appliances in contemporary orthodontics: Littlewood *et al* (*BDJ* 2001; **191**: 304–310).

While few would disagree with the basic thesis of this article ; that removable orthodontic appliances have less application than previously; it contained a few misconceptions of an historical nature.

In addition a somewhat restrictive definition was postulated of the range of circumstances in which the use of removable appliances in the mixed dentition is appropriate. On the historical side it is an oversimplification to believe that removable appliances were an almost entirely European concept and that fixed appliances were a rarity amongst UK orthodontists in the 1930s and 1940s.

Some of the best operators and innovators of removable techniques in the late l9th and early 20th centuries were American, for example Kingsley, Jackson and Crozat to name but three. The main problem with early appliances was their poor retentive properties. Consequently, the advent of the Adams' Clasp in 1949 was seen as such a significant event.[1]

Fixed appliances were used by orthodontists in Great Britain and Ireland in the middle of the last century. A number, such as Friel and McKeag, had been trained in the United States. According to Endicott in 1938,[2] fixed appliances were the principal system taught at the Eastman Dental Clinic at that time. It was the advent of the National Health Service in 1948 which stimulated the demand for orthodontics and the proliferation of the use of removable appliances in the hands of general dental practitioners, due to the lack of sufficient trained specialists.

One of the articles quoted,[3] in addition to showing the efficient correction of crossbites with removable appliances, also suggested that overjets could be effectively reduced.

This is of particular importance where upper incisor spacing is present. In addition, ectopic teeth such as incisors and canines can be effectively brought into line using the superior anchorage potential of removable appliances, mentioned in the present article, with the addition of a bracket or gold chain bonded to the tooth. Consequently; the range of capabilities of removable appliances in the mixed dentition is rather wider than that suggested by the authors.

The authors rightly point out, however, that one of the reasons for poor results being achieved with removable appliances is their use in patients with poor oral health and motivation, who do not reach the standards necessary for the use of fixed appliances.

W. J. S. Kerr, Glasgow

1 Kerr WJS. The rise and fall of the removable orthodontic appliance. *Dental Historian* 2001; **38**: 3-12.

2 Endicott CL. The work of the orthodontic department of the Eastman Dental Clinic. *Trans BSSO* 1938; 68-95.

3. Kerr WJS, Buchanan JIB, McColl JH. The use of the PAR index in assessing the effectiveness of removable appliances. *Br J Orthod* 1993; **20**:351-357.

Sir,— I read with great interest the paper on 'The role of removable appliances in contemporary orthodontics'.

Although the authors demonstrate the diminishing value of the removable appliance, I am sorry they did not mention the clinical situation where upper incisors are proclined, spaced and the overbite is reduced. These children are usually aged about 9 to 11 and run a high risk of trauma. A removable appliance can successfully reduce the overjet which can then be held stable with a removable retainer until more posterior teeth erupt and a further assessment made. If the child is still thumb sucking this is not necessarily a problem depending on the severity of the habit.

J. J. Crabb, York

The authors S.J. Littlewood, A.G. Tait, N.A. Mandall and D.H. Lewis respond:

We would like to thank Professor Kerr and Dr Crabb for their letters. They make very sensible points, which allow us to clarify aspects of the article further.

Firstly, we are delighted that Prof Kerr has expanded on the interesting area of the historical aspect of removable appliances. Initially we included many of these points, but due to restricted space they had to be omitted from the article. Perhaps more importantly both letters suggest other possible uses of removable appliances.

Although in our article we described removable appliances for correction of anterior and posterior cross-bites, we were careful to say that these were examples of their use. We believe that these are the circumstances in which they are going to be most useful and there is evidence to show they are effective in these cases. That is why these were illustrated in some depth.

However, there will be other situations when they can be used. As the article states, it is probably more important to recognise the more general principle that when removable appliances are used on their own 'they can provide simple, efficient and effective treatment to intercept the development of malocclusions, requiring limited tipping movements, using a single removable appliance in the mixed dentition'.

The crucial factor is to recognise that they can be effective when used in certain limited situations, but they should no longer be regarded as a second choice to fixed appliances when the patients' motivation or oral hygiene is not adequate: a point Prof Kerr rightly highlights at the end of his letter.

Orofacial pain

Sir,— Re the correspondence between R. Dean and the author G. Madland on orofacial pain (*BDJ* 2001; **191**: 418-419).

Let us retain some objectivity and not get into some of the dogma seen in the United States on occlusion, TMD and orofacial pain. Let it not be a matter of 'I've got more conventional references so I win', perhaps more 'I ask you not to believe, but merely not to disbelieve'.

S. Bray, Poole

Uncemented crowns

Sir,— Doubtless you will get many responses to the letter from P. Budden in the latest *BDJ* (*BDJ* 2001; **191**: 648).

I had a similar experience with a full gold crown in 1985, which I could not remove after trying in. The patient has been a regular attender at the practice since and the crown is still in place and still uncemented, and clinically and radiographically there are no problems.

But doubtless someone will be able to beat 16 years!

C. J. Rushforth, Bath