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.

A respected profession

Sir,— In March 1921, prior to the institution of the Dentists Act of that year, some editorial in the *BMJ* expressed the resentment of the GMC, 'which has not a dentist upon it', that the Government had forced this burden (dentistry) on them and 'medicine is a profession...dentistry is largely a business.'

Central to the aspirations of the new dental board, and expressed frequently by Sir Wilfred Fish in his years as chairman of the dental board and then first President of the GDC, was that dentistry become a respected profession and speciality of medicine. Reports of the early meetings of the dental board (and of the BDA) repeatedly express great concern about advertising and commercialism, and 'the list of bodies corporate in the 'business of dentistry''. Eighty years on, are we coming full circle?

J. D. Manson
London

Professional responsibility

Sir,— I was very interested to read the Leader on 'Professional Responsibility' in the *BDJ* (*BDJ* 2002; 192: 181). I believe there are a number of issues, which have relevance to this matter. In particular I would like to cite the forthcoming OFT investigation into private dentistry as a result of the 'Supercomplaint' made by the Consumers' Association, and the concern which has been expressed within the profession over recent years with regard to the lack of provision for the rehabilitation of patients with dental anxiety or phobia, following the curtailment of use of general anaesthasia in the general practice setting.

I have a particular interest in the psychological aspects of dental care, both from the point of view of the patient and from that of the dental team. A few years ago, I held a part-time post in a dental hospital setting, where I had responsibility for the rehabilitation and treatment of phobic patients. It was my policy to bring patients in to their first appointment, not for any examination or treatment, but simply to spend some time discussing with them their past experiences of dentistry in an effort to pinpoint the origins of their problems. Many patients expressed gratitude and relief that, at last, someone had taken the trouble to listen sympathetically over what, for them, had been emotionally very traumatic episodes, and quite often became tearful when relating their experiences. Listening to those experiences was sometimes difficult and embarrassing, in the knowledge that they were, at least in part the result of the behaviour of the members of my own profession, and I frequently felt justified in imagining the sound of lawyers' cash registers ringing in the background. There were numerous stories of abuse of trust, physical or emotional abuse, intimidation, total absence of communication or explanation, to name just a few. One practitioner even referred a patient to my clinic simply because he would not take the trouble to explain to her what root canal treatment was. Once this was done, her anxiety disappeared.

More recently, a new patient attended my practice on recommendation by two other patients, for a second opinion. A highly educated lady, for the last 20 years, she had been under the care of another local practitioner, who had been obliged to retire early on health grounds. She had been very happy with his care, requiring, for the most part, only occasional restorative intervention, in accordance with his conservative approach to care, and routine scaling and polishing. Prior to attending my practice, she had undergone a consultation at another local practice, and had been alarmed to be told that all her existing amalgam restorations required replacement, at a cost of £300 or 'possibly more'. As this was so out of keeping with her previous pattern of needs, coupled with the fact that her previous dentist had warned her about this kind of practice, she was, thankfully, frightened off. I say, 'thankfully', because, on the basis of my examination, she required just one new (not replacement) restoration and a simple scale and polish. Her relief, after the consultation with me, was such that she was moved to write to me a note of thanks 'for having restored her confidence in dentists and the job they do'. In passing, she also mentioned that she had recently met a couple at a dinner party who had related a similar story, in relation to the same practice, and both of whom had gone through the process of wholesome replacement of restorations, as recommended, returned to the practice for a six-monthly recall, expecting a clean bill of health, only to be told that further extensive work needed to be done. This was declined, and the patient left the practice. Whilst one cannot argue, without examining the patients, that such additional work might have not been justified, nor could one say the same about the original replacement of the restorations, because the evidence is gone, I would say this. In nearly thirty years of practice, during which I, like every other practitioner, have seen a large number of patients and a wide variation in the standard of treatment carried out by colleagues, I cannot recall any situation in which I have felt justified in removing and replacing every single restoration in a patient's mouth. Am I unusual or lucky? I don't think so.

We are now in the 21st century. The publics' perception of us, as 'drill and fill merchants', 'sadists with Bentleys' 'a rip-off', 'blood and acrylic operatives with little more qualification than an 'O'-level in woodwork', and the typical, regular, negative media portrayal of 'dentist drilling for the gold' and 'dentist extract more from your wallet' etc, are, I suspect, things that most of us would be glad to see consigned to the last century; back where they belong. Or are we going to allow them to contaminate the profession's existence in this new century too?

Although we may see them as a threat, the Consumer Associations' 'Supercomplaint' and the resulting OFT's investigation, also provide us, I believe, with a golden opportunity to show the general public that we want a better relationship with them, and are also prepared to grasp the nettle and do what is required to show them that we deserve their trust. This will require a level of honesty, openness and accountability that many will find unpalatable, but it is not all one-way traffic. Because alongside the opening up of the profession for scrutiny, there also exists an opportunity to educate

the public about dental matters, because there is a great deal of ignorance and misunderstanding out there, which is helping no-one. This requires a public that is willing to be educated, to abandon the myths and sometimes understandable prejudices that they bring with them, and to acknowledge that we have a point of view, too. In the face of criticisms we have the opportunity to say our piece about our level of qualification and skills, the contribution we make towards the general health and quality of life of the nation, our desire to achieve high standards of care for our patients, that we run businesses and need to earn a living and that we are, in the main, professionally responsible. It also requires a Government, which is prepared to be honest about what it can afford to commit to NHS dentistry, by what means, and to whom, and therein, perhaps, lies the rub.

Once the OFT investigation gets under way, I fervently hope that the profession's leaders, while listening to the criticism that comes, will not be cowed by it, and will take the opportunity to drive the profession's point of view home with all possible vigour.

But words are cheap. It is no use claiming that we are professionally responsible unless we are willing to prove it. 'Tarting up' our image by calling ourselves 'doctors' has backfired, and was never anything other than a cosmetic and self-congratulatory exercise. Now we need to 'get serious', and deal with those members of our profession who appear to lack even the basics of caring professionalism, who appear incapable of treating patients as people, of putting their patients' interests before their own, who are creating new generations of dental phobics, and who are giving the rest of us a bad name. Then, perhaps, we might look forward to a better public image in this century than we had in the last one.

G. Raven
Birmingham

Carious primary teeth

Sir, - Thank you for publishing a very thought provoking piece of research 'The fate of the carious primary teeth of children who regularly attend the general dental service' (*BDJ* 2002; 192: 219-223).

The most striking finding of this study was that pain and sepsis were as likely to occur in restored teeth as those left unrestored. Now of course we should not put too much weight on a single piece of research but I have to say that this finding supports my own clinical hunch that deciduous molars with two surface restorations are as likely to 'blow up' as their unfilled carious counterparts. If this is true, it creates a dilemma for GDPs. If simple fillings do not prevent pain and sepsis what should we to do for the young child with several carious primary molars? GA is largely unavailable now and multiple extractions of symptomless teeth under LA is likely to be unacceptable to both the children and their parents.

One alternative treatment philosophy was suggested by Professor Duggal in his commentary on the above paper. (*BDJ* 2002; 192: 215). He encouraged GDPs to adopt a more vigorous restorative approach involving vital pulpotomies and stainless steel crowns for any primary molar where decay has involved the marginal ridge.

There seem to me to be many problems with this as a general policy in the GDS. It would mean repeatedly subjecting millions of young children to a highly invasive, and prolonged form of treatment involving LA injections, amputation of vital pulp and full coverage crowns. This is treatment which many adults would have trouble coping with let alone 5 and 6 year olds which would be the age group most likely to benefit. This would surely be inhumane if a better alternative were available and could only be acceptable if we were absolutely certain of its benefits. Trauma to the patients, high cost and risk of clinical failure are all arguments against such an aggressive treatment philosophy.

So is there a better option? Yes. Instead of funding expensive and aggressive restorative treatment the money should go into higher capitation fees for the under 6s. This would encourage greater registration and carry with it the requirement of providing preventative measures of proven effectiveness.

These would include fissure sealants for first molars, topical fluoride and the free provision of fluoride toothpaste. The consequent great reduction in the decay rates for young children would mean that the few who did suffer serious levels of decay could be safely referred to specialist paedodontists for complex treatment.

D. Reekie
Kent

Sir, - It was interesting to read the article on dental pain and dental treatment of young children attending the general dental practice (*BDJ* 2002; 192: 280-284.)

The article, in short, concerns caries, restorations and dental pain. Caries in early stages can only be diagnosed by routine dental radiography. There is no mention of radiography in the whole article. By the time the dental caries is diagnosed clinically it is too late and beyond repair and that is why the level of restorative care in primary dentistry is less important.

Under the National Health Service regulations there is no payment for taking radiographs of children and as such not many dentists take routine radiographs of young children; thereby delaying the diagnosis of dental caries.

If one wishes to reduce dental pain in young children, effective methods of preventing caries must include routine radiography. The best and sure method of preventing further caries at individual level is a restoration.

Restoring teeth of young children is very difficult and time consuming and the payments under the NHS are very low which makes it very difficult for the dental surgeon to provide a quality restoration which can last.

I do understand that it is very difficult to write practice based articles but it is not fair to undermine the confidence of the profession in treating teeth with restorations.

L. K. Bandlish
London

Sir, - The paper by Tickle *et al* (*BDJ* 2002; 192; 219-223) identified a problem with the effectiveness of restorations placed by GDPs in the primary dentition. Their conclusion, albeit qualified, was that restorations placed in carious primary molars did not affect whether the teeth exfoliated naturally or had to be extracted because of pain and sepsis. Research in primary care is notoriously difficult to complete (and, therefore, far too rare), so perhaps the extremely pragmatic approach taken by the authors regarding both data collection and analysis in this preliminary study has to be viewed in that context. What I found surprising, though, was that of all the suggestions given by the authors as to why the restorations were ineffective, the possibility that the quality of the restorative care provided by the GDPs might have been a significant part of the problem was given only the lightest of touches. The case that restorative care of primary molars can be effective was well argued, with supporting evidence, by Professor Duggal in his research summary in the same issue of the journal. The uncomfortable fact is that the principles that determine the success or otherwise of restorations placed in primary teeth are exactly the same as those applying to restoring permanent teeth; *early* diagnosis of caries into dentine, *before* the pulp is involved (this usually involves radiographs), followed by

careful cavity preparation and restoration.

If restorations placed in primary care are so ineffective, should children only be seen by specialist children's dentists? Absolutely not; the technical skills required for children's restorative dentistry are no more than those required for adult restorative dentistry, and are often less; compare, for example, the technical demands of a pulpotomy with a molar root treatment, or fitting a preformed metal crown with carrying out a metal ceramic crown preparation.

The only thing GDPs need to provide quality restorative and preventive care for children is the one thing they have been denied by year upon year of inadequate funding, and that is time.

I hope that this paper will help gain funding for a properly conducted randomised controlled trial, but I would make a plea that the funding level applied for is sufficient to allow the GDPs the extra time they need to provide restorative care for their child patients of the same standard as they would apply when restoring an adult dentition. I think the outcome would then be very different from the one the authors found in their recent study.

D. Evans
Dundee

Sir, - The paper (*BDJ* 2002; 192: 219-223) seems to reflect the perceived view of GDPs by some academics. Most, if not all dental practitioners practice dentistry 'on sound scientific principles', equally they need to run practices on sound business principles, otherwise they would not be able to provide a service for anyone.

The authors' references does not include the study by Shelly and Mackaie that highlights the conclusion by Curzon and Pollard that 'the level of payments of general dental practitioners is such that they 'cannot afford to treat children.''

The discussion seems to not have considered this factor. Academics and policy makers in the UK must consider the lack of funding as a contributing factor in studies of this sort, to not do so is not looking at the complete picture and naïve.

V. Rawal
St Albans

1. Shelley A, Mackie I. *Dental Update*, Oct 2001.
2. Curzon M E, Pollard M A. *Br Dent J* 1997: **182**: 242-244.

Sir, — I enjoy having my prejudices confirmed and the article (*BDJ* 2002; 192: 219-224) supports my belief that paedodontic conservation as it is normally practiced has little effect on the survival of primary teeth and also comes with the added problems of physical and psychological effects of treatment on child patients. I suspect what partly underlies the paper's findings is that decay generally occurs in certain socio-economic groups and at present we have no realistic way of changing their oral environment. The caries reoccurs. Let us be realistic. If there is pain and the treatment requires an anaesthetic, extract the tooth. If there is no pain leave it alone. I can say that on those rare occasions where I have been able to change the oral environment with diet advice, fluoride mouthwashes and oral hygiene I have supervised moonscape primary dentitions to a caries-free secondary dentition with actually very little requirement for extraction, let alone attempts at restoration.

The next issue to challenge the paedodontists on is the value of stainless steel crowns on endodontically treated primary teeth, which was suggested as a predictable alternative. There are several questions here.

1. Is primary endodontic treatment really safe? Let us own up to the use of medieval medicaments in the pulp 'mummifying' process. There is a strange dichotomy that encourages this chemical approach to endodontics in children but significantly disapproves of it in adult treatment. Odd really because the last place one might suggest the use of any cytotoxic materials is in individuals with most cellular activity, e.g. children. I would not allow it in my child.
2. Is space maintaining really that useful? Have any studies actually confirmed the value of this in the real decisions made in the context of orthodontic treatment in later life? I suspect it has little value and actually extraction decisions can often be more easily made when there is overcrowding with all the potential benefits for impacted 8s erupting normally.
3. There is also the question of whether restoration treatment on primary teeth represents good value in health budgets. As there is certainly no proven case there is a stronger economic argument for the extraction of problem deciduous teeth.
4. Finally it is worth asking what are proactive restorative paedodontists trying to prove? There is undoubtedly great skill in paedodontic conservation, not the least of which is achieving the co-operation and trust of child patients.

The trust of a child is a sacred thing and persuation is power. In the context of so much uncertainty about the value of primary teeth conservation, clinicians who treat children this way should be very clear about their motives.

D. English
Norwich

Sir — Further to the articles referring to the fate of carious primary teeth of children who regularly attend the general dental service (*BDJ* 2002; 192: 219-224) and about pain and treatment of carious primary teeth (*BDJ* 2002; 192: 280-284), my practice was one of the participating practices providing data for the original research and I feel a slightly different perspective may be helpful. Although both sets of authors are careful in drawing conclusions without further research, the tone of both articles would suggest restoring deciduous teeth as it is performed at present is in fact a waste of time. Maybe two different scenarios may illustrate the point:-

1. A 4-year old attends with pain and an acute abscess. This is his first visit to the dentist and results in an extraction possibly with GA. Diet advice is given briefly on the day (he is fitted in as an emergency) and a further appointment is made for diet and OH control. Unfortunately the parents do not bring him back and his next visit is a few years later when the same experience is repeated. He now has caries in all his 6's and is a dental phobic.
2. A 4-year old attends with pain and several small carious lesions, which are duly restored, possibly using sedation. He has his OH and diet advice. He attends regularly, has several deciduous teeth restored, his 6's fissure sealed. Later the parents bring him in as he is having 'pain' with an exfoliating molar, which has probably been restored and may now be extracted. He is a confident patient who actually likes attending the dentist.

The statistics record both these patients as having had two episodes of pain and possibly two extractions. The fact that the second case has had deciduous teeth restored makes no difference to the fact that he has them extracted. The second patient has had many more interventions but with the same outcome statistically.

Which case is a success in the short term and what is the future prognosis for these children?

D. Whitehouse
Whitchurch

Martin Tickle and co-authors respond:

The interest generated by our research among academics is very welcome and reflects the importance of ensuring that the profession provides appropriate and effective care to children with carious primary teeth. The correspondents raise several points which we would like to respond to.

Professor Duggal provided a commentary on our paper but was not a co-author as V. Rawal's letter suggests.[1] *The recent paper by Shelly and Mackie*

makes an important contribution to the debate and illustrates the potential consequences for the GDS budget if GDPs were to wholeheartedly embrace the model of care advocated by the British Society of Paediatric Dentists (BSPD).[2,3] We agree that it is important to run a study with a strong health economics component, however, our study was preliminary in nature. In the sister paper, which reported the results of patient level analyses, we point out that we have found an anomaly that requires further investigation.[4] Future studies need to look at both the costs and benefits of different models of care.

Dr Evans misinterprets the findings of the study, stating that we 'identified a problem with the effectiveness of the restorations placed by GDPs.' Yet, we found that the great majority of restored teeth exfoliated naturally (93% of anterior teeth, 80.4% of first molars and 85.5% of second molars) as opposed to being extracted due to pain or sepsis.

We also found that only a small proportion of restored teeth gave cause for a course of antibiotics to be prescribed (11.3% of first molars and 8.0% of second molars). These outcome measures are perhaps more apposite to temporary structures than the 5-year survival rate of restorations employed by other, regularly cited studies.

In the paper by Roberts and Sherriff 5-year survival estimates for Class 1 restorations in primary molar amalgam restorations were 73.3%, and for Class 2 restorations 66.6%.[5] The results obtained by the GDPs in our study, over the lifetime of the primary dentition, compare very favourably with these results.

This is a significant achievement given that not one preformed crown was fitted by the dentists in our study. It would be interesting to see how care provided by specialist paediatric dentists compares with these results, if exfoliation is used as an outcome measure.

Dr Evans implies that our principal finding; that we could find no difference in outcomes of filled and unfilled carious primary teeth, is due to the quality of treatment provided by GDPs. Professor Duggal reached the same conclusion in his commentary on the paper.[1] This conclusion cannot be supported by the data presented, neither can the data confirm the prejudices admitted to by David English.

We gave three possible hypotheses to explain our findings: there really is no advantage in restoring primary teeth; the quality of the treatment provided by GDPs is no better than leaving teeth unrestored; GDPs are actively deciding which teeth to restore and which they can leave unrestored to reach the same result, which is exfoliation.

We favour the latter explanation, but cannot reach a firm conclusion due to the limitations of the study design. In order to provide an evidence-base for the dental care of young children we agree with Dr Evans that randomised control trials are required. However, further primary research studies are needed to justify a trial and develop the necessary outcome measures and methodologies.

It is important to think of the dental care of children in a holistic sense rather than simply treatment. This point is well illustrated by the letter from David Whitehouse, who draws attention to the potential for traumatic treatment interventions having a profound psychological effect on children.

There is a balance to be struck between the desire to improve clinical outcomes and the wish to minimise the possibility of any detrimental psychological effects of treatment. It is this balance that GDPs struggle with on a day to day basis in providing a service for the 5 million children under the age of 12 who are registered with a GDS dentist.[6]

It is clear that there is a discrepancy between the model of care advocated by specialist paediatric dentists and the care provided by GDPs.

This study has highlighted this situation and points to the need for a comprehensive research programme designed to look at a broad range of outcome measures. This is the only way a sound evidence base can be established for providing appropriate and effective dental care for children.

1. Duggal M S. Carious primary teeth: their fate in your hands. *Br Dent J* 2002;192: 215.
2. Shelley A. Mackie I. Case Study of an Anxious Child with Extensive Caries Treated in General Practice: Financial Viability under the Terms of the UK National Health Service. *Dent Update* 2001; 28: 418-23
3. Fayle S A, Welbury R R, Roberts J F. British Society of Paediatric Dentistry:a policy document on management of caries in the primary dentition; *Int J Paediatr Dent*; 11: 153-7.
4. Milsom K M, Tickle M, Blinkhorn A S. Dental pain and dental treatment of young children attending the general dental service. *Br Dent J* 2002; 192: 280-4.
5. Roberts J F, Sherriff M. The fate and survival of amalgam and preformed crown molar restorations placed in a specialist paediatric dental practice. *Br Dent J*; 1990; 169: 237-44.
6. Dental Practice Board electronic database of statistics: *www.dentanet.orcl.uk/dentanet/iJrof/dDb/index.html*