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.

Falling at the last hurdle?

Sir, — I am writing to express my concern about the dissemination phase of the National Programme for Primary Dental Care Research and Development. Many important projects were funded under this initiative and it is essential that their findings are not only reported in peer-reviewed journals, but actively disseminated to academics and practising dentists. There is no point paying for the development of sound evidence, if practitioners are not given plenty of help to put that evidence rapidly into practice! Yet, when visiting the website (*www.doh.gov.uk/nwro/pcdental/whatnext*), the pages on 'What's next?' and 'Conference/Workshops' are labelled as being 'under construction' and haven't been updated since August 2000.

I wonder if Professor Nigel Pitts would care to comment on this? This evidence on changing professional practice would seem to indicate that adequate resources must be devoted to this final phase of the R and D programme if value for money is to be obtained from the very substantial investment made in it.[1]

C. Stillman-Lowe
Reading

1. NHS Centre for Reviews and Dissemination 1999. Effective Health Care bulletin; 5: Getting evidence into practice.

Professor Cliff Bailey, director of the NHS National R&D Programme on Primary Dental Care says:
*The Dentistry Programme is only just beginning to take receipts of outputs, and dissemination plans, including a formal conference, are being discussed and planned for 2003. A major overhaul of the web-site is also planned. All peer reviewed final reports have an abstract posted on the Research Findings electronic register (*www.doh.gov.uk/research/rd3/information/findings.htm*) and are added as reviews are completed. Draft final reports are being sent to the Chief Dental Officer.*

Same dentist rule

Sir, — I wish to raise the issue of the 'same dentist rule' as it applies to oral surgeons and presumably other specialists working in general dental practice.

As you may be aware, the General Dental Services Committee [GDSC] set regulations to be applied by the Dental Practice Board when they consider payments for dental services within the NHS. One of those regulations concerns the limit of payment for an examination to once every six months for any patient seen in any one dental practice (with the exception of trauma) irrespective of who sees the patient. Therefore any dentist working in that building counts, for the sake of the regulation, as 'the same dentist' and this is known as the same dentist rule. Sadly, I, along with many other visiting practitioners have fallen foul of this regulation in that we cannot be paid for examining a patient who is referred to us for specialist treatment.

Specifically, I accept referrals for oral surgery from a practice I work in one day per week. Many of these patients are already in pain when sent to me. By seeing me, they can be treated rapidly with no long wait on hospital waiting lists. It is my legal duty to examine any patient referred to me as I have to ensure the surgery is necessary, likely to be beneficial, and so I can explain the procedure and give prognosis and cautions. The General Dental Council who are ultimately responsible for my fitness to practice advise that to do any surgery without an examination is unprofessional which could jeopardise my career.

However, I recently discovered that I was not being paid for the examinations I have to carry out as apparently I am classed as 'the same dentist' as I work in the same building as the referring practitioners. Naturally I contacted the DPB who have been most helpful. They can see the anomaly and felt it was unfair on me. They have correctly advised me that GDC guidelines tell me I must do any examination but due to the unfair nature, they suggested I contacted the GDSC who set the rules to get this anomaly altered.

The GDSC in their turn have also told me I must do the examination but the current rule still applies and that I cannot be paid for it. (No wonder dentists wish to leave the NHS!) Tony Kravitz, the chairman of GDSC tells me they have tried for some time to get the rule changed but that the Department of Health are the sticking point. It seems therefore that both the DPB and the GDSC, and I believe anyone with any sense, can see this rule is unjust and unworkable. With the blessing of the GDSC I wrote to the Department of Health some time ago, but they have not replied. I am obliged to do an examination in order not to be brought before a professional conduct committee, so why should I not be paid for it? Can the Department of Health immediately set about changing this out of date rule to allow local specialists to help reduce waiting lists?

In the meantime how does the Department propose I treat people who are referred to me? It appears under the current rules I have one of four options :- (a) ignore GDC guidelines and do surgery without an examination (and get struck off); (b) do the examination for free (why should a professional do something for free?) or (c) charge the patient privately for NHS treatment that is being done in order to help reduce NHS waiting lists (which will not look good in the newspapers) or (d) make the patient wait 6 months (even if they are in pain) and tell them not to go back to their own dentist in the meantime. If they do see him/her for any reason, then they must wait to see me for another 6 months - *ad infinitum*?!

R. B. M. G. Kitchen
Bristol

GDC registration fee

Sir, — Recently in the *BDJ* and *GDPA Journal* there has been considerable correspondence about the proposed, but inevitable, increase in the GDC registration fee. It would seem that the profession, as a whole, is impotent yet again to do anything to prevent its taking effect. I wonder how many colleagues will be removing their name from the register because they are unable to practice and

have retired on medical grounds, and that the increase in the fee and the financial demands of CPD are prohibitive on a limited income. Presumably this will mean a reduction in the overall income to the GDC. Has this been predicted?

As there are major upheavals of this sort now about to occur, maybe we should be looking realistically and radically at the practice of dentistry in the UK. Is it not time for the profession to say enough is enough? If the Government really does want a 'National Health Service' maybe this should be provided by employed dentists in totally NHS Centres. If the success of the access centres is to be believed surely this is a pragmatic option, always assuming, of course, that the dentists working in those centres are paid a viable salary in line with consultants and have a defined career pathway. This would then free up general dental practices to provide realistically funded services to the very highest standards.

Yes, this is a radical step to take. Of course it might be possible for the government to 'buy-in' from general dental practice at commercially competitive rates. It might also make the mandarins realise the full complexity of dental practice and its financial implications. After all, the access centre dentist appears to treat as many patients in a full week as the average high street practitioner does in one day!

Joe Sullivan suggests in the leader of the GDP of June 2002 that the official figures equate to £266 being the cost of treating each patient. Perhaps this should be the basis for funding the new arrangements?

N. R. Winter
Kent

Nail on the head!

Sir, – A.J. Preston (*BDJ* 2002; 193; 2) appears to win the archery competition with the bullseye!

C. Scully CBE
London

Student addiction

Sir, – I read with great interest the paper on drink, drugs and depression in a UK dental school by D. Newbury-Birch *et al* (*BDJ* 2002; 192; 646-649).

The Dentists' Health Support Programme (DHSP) are finding that addiction problems among students and young dentists are increasing within all dental schools. This paper adds to the growing body of evidence that reveals a problem among our young colleagues that should not be ignored or dismissed as just part of 'lad/ladette culture'. Some of the anonymous cohort of students who completed this questionaire will inevitably lose their professional careers and their good health unless they are given help.

The DHSP are grateful for their mention in the discusion section of this paper and I would like to take the opportunity to publicise our telephone number – (020) 7487 3119 . Calls are completely confidential and will provide contact with a professional colleague who can offer assistance in the light of their own life experience.

P. J. Davenport.
Chairman of the Management Group of the Dentists Health Support Programme
Birmingham

Study of GDP work

Sir, – I write as one of the co-authors of the recent paper by Tickle *et al* (*BDJ* 2002; **192**: 219-224). I am a general dental practitioner and while Dr Tickle has responded admirably to the correspondence generated by our research, I wish to add my comments based on my own clinical perspective. The paper reports the findings of a retrospective study and is not a critical review of the work of general dental practitioners.

The origins of this research can be traced back to a peer review group of four general dental practitioners who discussed the way they treated decayed deciduous teeth, and the ways in which their treatments had changed over the years. As usual, when even four dentists are gathered together, there was no consensus of opinion. Some intervened more than others, some filled small cavities but not large, and some extracted more readily than others. None of us, however, ever fitted stainless steel crowns.

Dr Reekie rightly points out that there is a real dilemma for GDPs, as treatment options for large cavities alone may vary from a minimal intervention to the treatment advocated by Professor Duggal – that of vital pulpotomies and stainless steel crowns. Though I do not doubt that this approach can succeed, I agree with Dr Reekie that there are many problems with this type of restorative care. The fact that GDPs are not providing this treatment is shown from DPB statistics which indicate that the total number of stainless steel crowns provided in the year 2001 was only 4255. Though I would agree that a more preventive approach should be encouraged I would take issue with his final suggestion that those with serious levels of decay should be referred to a specialist, presumably for the invasive treatment previously described. Where are

these specialists? Even if they were available our research suggests that type of care is unnecessary.

I also agree with many of the comments made by Dr Bandlish, including the fact that early decay is better diagnosed by radiography. He points out that not many dentists take routine x-rays of young children, and there are no financial incentives for doing so. However I cannot agree that routine radiography is an effective way of preventing caries, nor that placing a restoration is a sure method of preventing caries. One is a diagnostic tool and another is a method of removing diseased tissue, but neither are preventive measures. I must furthermore assure Dr Bandlish that the purpose of this research is to provide an evidential base, and is not aimed at undermining confidence of the GDP in treating the decayed deciduous dentition.

Dr Rawal seems to feel that the paper is a criticism of GDPs by academics, and though I feel that most practitioners do what they do with their patients' best interests at heart, I cannot agree that this is necessarily based on 'sound scientific principles'.

Dr English seems to follow an approach to treating children that is similar to my own, except that extraction is even further down my own list of treatment options. Where he feels he has been able to change the oral environment, he describes a situation we must all have seen where a decayed deciduous dentition passes into a decay free permanent dentition with little need for intervention. He also raises the question of space maintenance and its usefulness, but unfortunately our work has so far been unable to include this interesting area.

Finally Dr Whitehouse suggests two scenarios that are open to varied interpretation. Firstly, the 4-year old patient presents with pain and has an extraction, possibly with a GA. Why a GA? Patients who have had a GA are shown to be more apprehensive, so why not provide a course of antibiotics? This will remove the symptoms, the patient remains unaffected by an unpleasant invasive procedure, and the dentist has a breathing space to pursue further approaches. In the second, the 4-year-old presents with pain and small lesions. Unless there was severe food packing, it is likely that the pain is actually being caused by far greater pulpal changes than may be apparent, and these are exactly the sort of restorations that probably have a poor long term prognosis. Attempts to change the patient's diet is admirable, but as Dr English points out, we should be humble when considering our abilities to change the oral environment.

My involvement in this paper has been a fascinating personal experience, and shows how exciting research in primary dental care can be. The paper has demonstrated what we probably all know – that there are many different approaches to treating the decayed deciduous dentition and that most of our outcomes are successful.

However, there is more work to be done and as researchers always seem to say, and as Dr Evans suggests, further funding for further research is essential!

D. King
Bollington

Dentists practising CAM

Sir, – It is of great concern that some dental practitioners are practising CAM (complementary alternative medicine)

Random drug testing

Sir, – I read with interest the paper published recently (*BDJ* 2002; 192: 646-649) reporting on a longitudinal study of alcohol, illicit drug use and anxiety among a group of Newcastle dental undergraduates from their second year to one year after working as a qualified dentist.

The authors should be congratulated for this study, especially for its longitudinal nature. However, one of the conclusions the authors drew from their results was that random alcohol and drug testing should be introduced to minimise alcohol and drug use in the profession. I feel this recommendation requires further clarification for two main reasons.

Firstly, this recommendation cannot be justified from the study reported, as at no point were those surveyed asked whether their alcohol and drug use would have been less if there were the chance of being randomly tested. Secondly, the threat of random alcohol and drug testing as a method of minimising a group's use of these substances has many drawbacks:

(i) Random drug testing has been shown to be ineffectual and its introduction in prisons is thought to have resulted in inmates switching from cannabis, which can be detected in the body for up to four weeks to heroin, which only remains for up to three days in the body.[1,2]

(ii) The financial cost of introducing random testing would be immense and with the current level of understanding of the issues unjustifiable.

(iii) Legally random drugs testings may not be possible (although there is yet to be a test case) under Article 8 of the Human Rights Act, concerning an individual's right to privacy.[3]

(iv) Deceiving the tester is not difficult, with a basic search of the Internet revealing multiple methods.[4]

More research of the type carried out by the authors is needed before there can be an informed debate regarding the concern surrounding dental professionals use of alcohol and drugs.

B. Underwood
York

1. DuPont R L. Stopping alcohol and other drug abuse before it starts: the future of prevention. Rockville, MD: Office for Substance Abuse Prevention, 1998.
2. Druglink. Failing the test Druglink 1998; 13: 7.
3. Alcohol Concern 2002. Alcohol and drug testing in the workplace (www.alcoholconcern.org.uk/Workplace/glancesheetno6.htm).
4. Hayes G. Deceiving the tester, drugs: your questions answered. 2nd ed: 166-167. London 2000.

The authors of the paper respond:

Dr. Underwood raises some pertinent and important points regarding alcohol and drug testing. It is worth noting that alcohol and/or drug testing has been called for and even by medical students themselves.[2,3,4,5]

The results of this present study and others show that there is a problem with alcohol and drug misuse amongst dental and medical students and newly qualified doctors and dentists and steps need to be put into place to ensure that no patients are ever put at risk by a doctor or dentist who is under the influence of alcohol and/or drugs.[6,7] *We believe that the time is right for a sensible debate on the whole subject of misuse in both the medical and dental professions.*

1. Newbury-Birch D., Lowry RJ, Kamali F. (2002) The changing patterns of drinking, illicit drug use, stress, anxiety and depression in dental student in a UK dental school: a longitudinal study. *Br Dent J 2002*; 192: 646-649.
2. Christie B. (1997). Inquiry calls for doctors to be tested regularly for alcohol. *Br Med J* 2002; 314: 769.
3. Lennon MA. (2002). Drink, drugs and depression in dental students. *Br Dent J.* 2002; 192:11: 636
4. Sellappah A. (1999). Consumption of drugs and drink among junior doctors [letter]. *Stud Br Med J;* 7: 32.
5. British Medical Association. (2000). Tomorrow's Medicine Today - Medicine in the New Millennium. Medical Students Conference 2000, St. Andrews University, Scotland.
6. Newbury-Birch D. White M. Kamali F. (2000) Factors influencing alcohol and illicit drug use amongst medical students. Drug and Alcohol Dependence; 59:125-130
7. Birch D, Ashton H, Kamali F. Alcohol drinking, illicit drug use and stress in junior house officers in north-east England. *Lancet* 1998: 352:785-786

therapies without either adequate training or CPD, which are required by the GDC's code of practice and education.

The GDC and BDA have failed to respond to the efforts of dental practitioners using CAM therapies who are striving hard to get recognition of their CAM qualifications in order to strengthen the bond between practitioners and their associated professional bodies as well as the dental protection organisations such as the MDU and MPS.

At present, thanks to the House of Lords Science and Technology Select Committee, the GDC is working towards education at the undergraduate level in CAM therapies so that newly qualified practitioners gain an awareness of the use and practicality of complementary medicine in the practice of everyday dentistry. But this is not nearly enough. In order to protect our profession and our patients, the GDC and the BDA should demand that dentists using CAM therapies are properly trained and qualified in those therapies.

Therapies such as acupuncture and homeopathy have governing bodies in the British Medical Acupuncture Society and the Faculty of Homeopathy. Surely the GDC and BDA should formally recognise the training and qualifications of these bodies and made it a requirement of GDC registration that any practitioner using homeopathy or acupuncture should have a current qualification backed up by CPD? Instead, they are adopting the ostrich position and hoping the potential minefield of issues around fitness to practice and patient safety will just go away. This is neither in the interests of our profession or of our patients.

P. Darby
London

Unethical selling

Sir, — Once again your editorial (*BDJ* 2002; 192: 485) hits an important nail squarely on the head. Many dentists will be familiar with the situation of knowing what is clinically right for a patient yet their recommendations are ignored.

One way to avoid the danger of unethical selling is to formally assess the patient's experience of his/her dental condition. Greater emphasis on subjective experience is compatible with the WHO definition of health as the complete physical, psychological and social well-being and not merely the absence of disease. It also recognises that dental treatment aims to improve quality of life rather than simply remove disease.

Although dentists are very skilled at clinical assessment it is not without its problems.[1] The very exclusive nature of professional assessment can be questioned from an ethical perspective as it inhibits consumer participation in health care. Dental check-ups focus on diseased organs (teeth, mucosa etc) rather than the functioning of the oral cavity or the person. Consequently the norms of dentists do not correspond with functional norms or the social needs of patients and so treatment needs assessed by dentists are often high. Similarly, clinical assessments ignore the social and motivational factors associated with the onset of disease and the success of treatment. As consumer affairs TV delights in pointing out, professional assessments of clinical status can be subjective and unreliable. Lastly, clinical assessment can exclude alternative approaches to health care, particularly health promotion.

Clinical assessments are essential to determine the treatment that might help a patient and early diagnosis and treatment (of dental caries or malignancy for example) can be useful before there is an impact on the person.

There are other situations, such as orthodontics and fixed and removable prosthodontics, where the benefits of treatment can be debatable. A good clinician will always consider the patient as a whole. But it is now possible to supplement clinical examinations with a formal assessment of the impact of the mouth on the patient using a measure of Oral Health Related Quality of Life.[2]

One reason for low uptake of treatment is that some people may not be aware of the possibilities open to them. Indeed, by the time a person enters the surgery and becomes a patient the battle is half won. Health promotion can be used to increase expectations of health and knowledge of treatment.[3] However, such activity may not be advisable without evidence of the types of dental treatment that effectively improve the patient's quality of life.

P. G Robinson
Sheffield

1. Sheiham A, Maizels J E, Cushing A M. The concept of need in dental care. *Int Dent J* 1982;32:265-268
2. Slade G D. Measuring oral health and quality of life. University of North Carolina-Chapel Hill: University of North Carolina-Chapel Hill, 1997.
3. Carr A J, Gibson B, Robinson P G. Measuring quality of life: Is quality of life determined by expectations or experience? *Br Med J* 2001;322:1240-1243.

Professional development

Sir, — In the chief executive's report in the winter 2001 issue of the *GDC Gazette* Mr Townsend claims that the profession's support for mandatory CPD was confirmed by positive feedback received in a survey of 11,000 dentists participating in the council's voluntary prepatory scheme (SIC). However, it must be pointed out that such support is not indicative of support among those participating. Thus the support by the former group would be greater than the support by the profession as a whole.

The true level of support for mandatory CPD by British dentists certainly needs to be determined. However, this requires analysis of the responses from a representative sample of correct size. Obtaining such a sample and conducting the survey requires the services of a statistician and inevitably entails some cost.

However, such cost is unavoidable if accurate results are to be obtained. Inferring from a small, unbiased sample, as Mr Townsend has done, can only give incorrect results and a wrong impression.

J. S. Smyth
Erina, Australia

Antony Townsend, Chief Executive & Registrar at the General Dental Council responds:

Last year, in advance of the GDC's CPD scheme becoming mandatory, the GDC surveyed all dentists participating in the GDC's voluntary preparatory scheme.

The aim was to gauge levels of participation in CPD, attitudes towards CPD and identify any areas of concern, for example where CPD may be found to be lacking in certain geographical or subject areas.

Although a survey of all registered dentists was considered, it was decided that dentists in the preparatory scheme might be more willing (and perhaps better placed) to offer feedback. 56% of those on the preparatory scheme responded - representing about one in six registered dentists. The survey results were reported in the dental press and can also be found on the GDC website, www.gdc-uk.org.

As Mr Smyth points out, the results of the survey cannot be taken as indicative of the views of every member of the profession. The survey was inevitably partial, and the sample not truly representative, but the results were nonetheless encouraging.

So is the fact that our scheme was developed in collaboration with, and has the support of the major professional organisations which represent a large proportion of the profession, including the Faculties, universities, postgraduate dental deaneries, and specialist and professional associations. The fact that over a third of registered dentists joined the voluntary preparatory scheme is also impressive.

More information on the scheme can be found on the Council's website or by phoning the CPD Information Line - 020 7887 3833.