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

Abstract issue

Sir,- I do wonder sometimes about the thinking behind some of the research reported in the *BDJ*. Take for example the abstracts in *BDJ* 2003, **195**: 447. There are two abstracts (Nutrition; Periodontics and Periodontology; Obesity) which if skim read, might lead the reader to think that alcohol consumption and obesity were associated with periodontal disease. A closer look at the abstracts reveals that no objective recordings were made of oral hygiene or plaque. Some nice stuff about multivariate statistical modelling was chucked in, but what about the scientific principle of cause and effect? How much more useless information do we need? Remember periodontal disease and associated coronary heart disease?

R. Spittal

Weston-Super-Mare

Dr Trevor Watts who chooses and edits

Abstracts replies: I thank Dr Spittal for drawing attention to this matter, and I share some of his feelings about unsatisfactory aspects of research studies.

Even classic studies may have their weaknesses, and journals which started off with a good name and good intentions sometimes print horribly bad papers which are systematically demolished in postgraduate journals meetings in my teaching hospital. I am also delighted that Dr Spittal read the 'small print' of my abstracts, which was intended to show precisely what he noticed. In my personal selection of papers to abstract, I reject many studies for a variety of reasons.

However, I occasionally draw attention to shortcomings which were not highlighted in the papers in question. One aim is to help researchers, whether seasoned or in training, to design better studies in the future. Another aim is to show those who are not researchers some of the unsatisfactory aspects of published studies. As a frequent referee of research papers, I know how bad some rejected manuscripts are. If every imperfect study were rejected, not much would be published. Science is a human activity and

subject to human weakness and error.

Think of some of the upheavals in physics over the past half century. Yet the physicists deal with matters which are intrinsically far less complex than human biology. All professionals need to know about the problems of research and especially about the difficulties of proving causality. What a public health disaster, for instance, was caused by the 1998 paper in the Lancet, based on findings from just 12 children, and suggesting a possible causal relationship between the MMR vaccine and autism!

And yet the largest study on this matter (from 500,000 Danish children, in the New England Journal of Medicine, November 2002) actually shows a trend towards a protective effect of the vaccine in question, though it does not reach statistical significance. Such an effect might exist, because rubella sometimes may apparently cause autism. Very recent work in the USA (JAMA, July 2003) shows that autism has a strong relationship with reduced head size at birth, and excessive head growth within the next year. This suggests that autism is very frequently determined long before MMR is given (typically at around 17 months in the Danish study), and hence by other causes. I believe that we should know some of the shortcomings of research, as well as its successes. I try to reflect life as it is by including a little of both in my abstracts.

doi: 10.1038/sj.bdj.4811044

Oral health care

Sir,- I quote from a letter from F. Dean in *BDJ* 2003, **195**: 423 'If the missing 50% of the general population were to suddenly start attending our surgeries, how many of us believe that the Government would double its financial commitment to dentistry?' This statement is based on an assumption that *per capita* costs are static.

Does this statement demonstrate a lack of awareness of the changes that have occurred in the oral health marketplace? I specifically state oral health marketplace not the dental marketplace. The number of courses of treatment requiring 'no dental

intervention' have increased by 10% between 1993 and 2003 and if epidemiological trends are taken into account this will probably increase in the next 10 years. The number of restorations required per course of treatment are fewer today compared with 20 years ago. The type of restorations placed today are often less time consuming than those placed 20 years ago (with the advent of adhesive dentistry). Clearly we do not want to undervalue optimum performance when comparing like with like but we have enough evidence to show the epidemiological changes since the NHS began in 1948. From a health perspective the greatest need for care is in the lower socio-economic groups yet the greatest demand for care is from the higher socio-economic groups. Supplier induced demand in the dental marketplace has been reported in the literature^{1,2,3}, this does little to improve oral health. Is there not an opportunity for dentists to impact on oral health and receive funding through being responsible for a section of the community? This way we do not depend on items of service and the treadmill effect. The missing 50% can be targeted and the currently presenting 50% can be appropriately managed through modern approaches.

Our 'customers' are the Government and individual patients. Clearly the Government is happy to purchase changed services within the NHS^{4,5} and privileged patients are currently content with the *status quo*. Of course third party agents could also impact on the situation as an intermediary in the dental marketplace, F. Dean refers to this in his letter. Julian Tudor Hart⁶ writes with regard to doctors: 'Professionals actually responsible for delivering care to whole populations know that the people with most to gain from relatively simple but effective care are those with least access to it, who are the most difficult to reach by proactive measures, and are the least attractive to traders in care as a market commodity'. Registration and treatment need are not synonymous, we therefore need to consider the benefits of

registration as a tool for embracing change thereby rewarding good practice and health generation. It will be interesting to observe whether we as dentists decide to continue as traders in care as a market commodity with undefined numbers of customers or welcome the opportunities presented for future full-employment in oral health care.

W. Richards

Glamorgan

doi: 10.1038/sj.bdj.4811045

1. Birch S. The identification of supplier inducement in a fixed price system of health care provision: the case of dentistry in the United Kingdom. *J Health Econ* 1988; **7**: 129-150.
2. Casals E, Gomez A, Cuenca E. Trends in manpower and utilisation of dental services in Catalonia, Session C1 Health Services Research, 8th Annual Conference of The European Association of Dental Public Health (2003) Jyväskylä, Finland.
3. Oliver A. Reforming public sector dentistry in the UK *Br J Health Man* 2002 **8**: 212-216.
4. Department of Health NHS Dentistry: Options for change (2002).
5. Welsh Assembly Gov Routes to Reform A Strategy for Primary Dental Care Wales (2002).
6. Tudor Hart J. Commentary: Can health outputs of routine practice approach those of clinical trials? *Int J Epidemiol* 2001; **30**: 1263-1267.

Postgraduate complexity

Sir,- M.E. Curzon's 'Alphabet Soup', (*BDJ* 2003, **195**: 429) highlighted the complexity of postgraduate education in dentistry today. The worsening financial burden and debts of aspiring specialists and those wishing to continue further postgraduate training/education was also highlighted.

The expense of examination fees, courses, living costs and not to mention subscription fees on successful completion places further financial burden. The current cascade of ever increasing postgraduate qualifications understandably confuses both the public and vast majority of fellow dentists. Participating in these courses is not only beneficial to patients and the profession in general.

However do we need to recite these letters after our names? Would it not be more transparent to simply confirm one's specialty after the surname, leaving all the hard earned letters to impress on CVs? With the prospect of 'top up' tuition fees lingering, how will future trainees manage this burden in years to come as the level of undergraduate student debt rises amongst newly qualified dentists? Average debts are already in the region £15,000 on graduation! One must wonder how future young aspiring dentists will view this, should they grasp the chance of postgraduate education and resign themselves to a life of debt and swallow their own 'Alphabet Soup'?

T. Idrees, Ashton-Under-Lyne

U. Qureshi, London

doi: 10.1038/sj.bdj.4811046

Legal loophole

Sir,- Through our work specialising in dental negligence we have discovered a very concerning legal loophole. Whilst it is best practice for dentists to have indemnity insurance, it is not a legal requirement for them to do so. The result is that if a dentist runs amok and fails to keep up the premiums or behaves in such a way that their dental defence organisation, (which are discretionary organisations) is unhappy with their conduct, then claims for negligent dentistry may not be met by them. We understand that there is a significant group of dentists in the South East who consider that there should be a fund set up to meet the claims of uninsured dentists so that it is not the innocent patients who suffer. This proposal would meet the question of compensation.

It could be a fund set up by the GDC with contributions being made by all practising dentists or it could be a fund set up by the dental defence organisations with the dentist contributing to such fund by increased subscriptions. Turning to the question of compulsory insurance it is inadequate for it simply to be a requirement for a dentist to be a member of a defence organisation because defence organisations are discretionary.

The law ought to be changed to make it a legal requirement for all dentists to have indemnity insurance and/or for the GDC to make it compulsory. It should be a very straightforward question to determine in the event of an investigation. We submit that any dentists not having appropriate indemnity insurance should be dealt with in a stringent fashion by the GDC. We would very much welcome the comments of your readers.

S. Mynard

Brighton

doi: 10.1038/sj.bdj.4811047

Super bugs

Sir,- I have recently had to introduce a new form of cross infection control measure into everyday life – the wearing of a rubber swimming hat. This is as a result of finding a freshly transferred human head louse (*Pediculus Humanus Capitis*) on to my head. After I had just finished treating a young girl with very long hair, my observant dental nurse noticed a 'bug' crawling around in its new home, my head. Fortunately, there was only one visible in my very short and sparse thatch, and it was very easily removed, and luckily for me, (and my family), that was the end of my introduction to nits! However, it did make me think that we must all be extra vigilant

to yet another possible hazard we meet at the sharp end everyday, particularly as head lice seem to be endemic in our area and indeed countrywide, as I am reliably informed by our local pharmacist. Modern day treatments such as malathion are also becoming ineffective, as the new breed of super mutant head lice are often resistant to current medicaments. It may also explain why there were a large number of dentists with shaved heads at a recent course held in London; prevention or cure? One will never know.

P. D. Copson

Wiltshire

doi: 10.1038/sj.bdj.4811048

Training pathways

Sir,- Having graduated in 1992 and at long last taken my last pre-consultant examination I wonder if I could present a few thoughts regarding specialist training and in particular orthodontic training? There is a realisation that you do not need to train as a consultant general surgeon to perform all appendectomies, nor do you need to train as a dentist to carry out simple restorative work or periodontal care. Similarly you do not need to train as a specialist in orthodontics to treat a anterior crossbite using a removable appliance. It makes sense to place the condition at an appropriate level within a system of treatment providers.

There is a shortage of orthodontic specialists in the UK, however, there are many more applicants than Specialist Registrar (SpR) training posts. In addition, the majority of orthodontic treatment subcontracted from the General Dental Services is performed by generalists, some of whom would consider formal orthodontic training provided it was given in a manner that suited their needs and formal recognition of this training was given. The current qualifying examination for the award of a Certificate on Completion of Specialist Training is the MOrth awarded by one of the Royal Colleges. This is typically taken during a 3 year full-time training course. Orthodontic trainees can pay up to £15,000 for this training in contrast to medical/surgical SpRs who receive training without the payment of fees. Entry onto a training programme is by necessity selective but I feel it is also restrictive. Many suitable trainees are prevented from securing SpR training as the number of posts is limited by central funding, however, as mentioned previously the number of training posts is insufficient to meet the manpower requirements of the orthodontic service. Restriction arises from several sources; one being the need to have undertaken hospital employment

as a junior member of staff but also the geographic distribution of Dental Hospitals will provide a barrier to some potential trainees. Does specialist orthodontic training need to have a Dental Hospital attachment? After all our medical/surgical trainees do not need to attend a medical school. I feel that the training requirements for specialist practice and hospital consultant are very different. Those wanting to train as hospital consultants should competitively apply for training programmes of 5 continuous years. Their training should focus on interdisciplinary care and the treatment of the most complex malocclusion. They should undertake a research degree, sit the MOrth and an exit fellowship. Training should be fully funded by the Postgraduate Dean.

Those who wish to train as orthodontic specialists with the aim of independent high street practice do not need training involving interdisciplinary care and the most complex of cases, nor do they need a research degree. An understanding of scientific methodology and statistical analysis is useful to be able to critically appraise the literature and this could be provided as a module within the training programme. I see no reason why the number of these training posts should be

limited by anything other than local training needs. Such training could be self funded or supported by a Primary Care Trust in an area of specialist shortage.

Finally, the appropriate examination for the end of specialist training is the MOrth and this should continue, however, the trend for MOrth candidates to present ever more complex and interdisciplinary cases should be stopped. The examination should be the marker for high street practitioners whose role is to treat many mild to moderately severe malocclusions to a high standard. Similarly, hospital consultants should not take on the role of a specialist practitioner just because there is no local specialist, instead they should be treating appropriate cases and providing training where it is needed.

I feel that the roles of the specialist practitioner and consultant are very different; as a result their training needs are different. It for the orthodontic body to recognise this and develop an appropriate system of training and treatment such that the trainee or a particular patient can be placed at the most appropriate position within the system.

S. Ward

Stockport

doi: 10.1038/sj.bdj.4811049

What's in a name?

Heartiest congratulations to all involved in the launch of *Vital*, the superb new magazine for the dental team. It reads, looks and feels good and matches the high standards set by *BDJ* publications. Surely it will soon appear more frequently than four times a year! May I shed some more light on the origin of the name Professionals Complementary to Dentistry (PCDs), which – it is disappointing to read in Opinion (*BDJ* 2003, **195**: 481) – causes so much resentment. The GDC's Dental Auxiliaries Review Group agreed that 'auxiliary' was an outdated term. They looked for possible inspiration to the Council for the Professions Supplementary to Medicine which registered physiotherapists, speech therapists, radiographers, occupational therapists and many other health professionals. It was considered that 'supplementary' did not convey the team concept so the word 'complementary' was substituted. Likewise, to designate dental hygienists and therapists as members of separate professions went against the desire to develop the dental team so it was considered more appropriate to consider all team members as professionals of the one profession: dentistry. Amazingly, the name PCD was speedily adopted by the BDA and the

rationale for the change was well understood by those responsible for granting the legislation necessary to allow statutory registration of current and new team members. Now, with *Vital's* timely assistance, I hope we can focus on the outcome of what must be seen as the most far-reaching advance for all members of the dental team and put acronyms on the back burner!

M. Seward

Bournemouth

doi: 10.1038/sj.bdj.4811050

Sir, – I think your editorial by Kate Craig (*BDJ* 2003, **195**: 481) says it all. I was one of the examiners at the November Dental Nurses National Examination. In an effort to put candidates at ease, I thought I would start their *viva* with a nice easy question. The question was, what is a PCD or what do those letters mean? Not one single candidate, male or female, was able to give me the correct answer. When I asked if they would be surprised to know that they were a PCD, they looked at me as if I was from Mars. Is it perhaps not time to drop the unpopular name PCD and return to terminology that all of our profession understands but more importantly our patients?

J. H. Hardy

Surrey

doi: 10.1038/sj.bdj.4811051