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

An imperfect system?

Sir, I have worked in the GDS since 1963. A significant part of my income still comes from the GDS. It is an imperfect system, but possibly the least bad one for patients, taxpayers and dentists. During the later 1960s, 70's and 80's the DDRB recommended take home pay (albeit lower than we thought we deserved) whilst the DRSG calculated (fairly accurately) expenses, and thus recommended turnover.

With the destruction of this system in the early 1990's, there is no longer any fair way of calculating changing practice expenses. Having met members of the DDRB believe that they know very little of the GDS. This is demonstrated by their reports of the last few years. They do not seem to be aware that dental inflation has little connection with the RPI.

Since the demise of the DRSG there has been no reflection in the SDR of the increase in the cost of changes in either clinical practice or the administration of a practice; nor has there been any change in the narrative of the SDR, nor of its relativities. Ministerial announcements of a little money here and a little money there is absolutely no substitute for proper reimbursement of expenses to all dentists.

For example, the practice of endodontics has changed immeasurably in the last ten years, as have the costs of both the capital equipment and disposable items required. There has been no recognition of this in the SDR. Endodontics fit for purpose is now carried out pro bono within the GDS.

Administrative costs have been increased by, among many other things, the still increasing cost of disposal of clinical waste, radiological protection, increased NI payments and the time required for clinical governance and quality assurance. These may all be worthy and desirable, but without the mechanism of the DRSG virtually unpaid for. It is surprising that there are so many of us still working in the GDS. Are things really going to be better next October for dentists, patients and taxpayers?

The underpayment of practice expenses will be built into the new system. With a payment system that is an amalgam of capitation and salary there will be a lot less dentistry carried out in the GDS. Is this an advantage for patients? The taxpayer at least will gain, for at last the Department of Health (DoH) will have what it has long wanted; a cash limited GDS. To achieve this, the DoH seems to be throwing out the baby as well as the bathwater.

Unfortunately the CDO and his advisers do not always appear to understand the GDS, or the running of a practice. Those of us who have borrowed large sums of money (ie most of us) to provide the capital for the GDS will take his reassurance on page 12 of his latest Digest with a very large pinch of salt. A three year contract is no basis for borrowing, let alone lending, large amounts of money, whatever the British Bankers Association says.

We are assured by ministers that the funding is there for three years and that there will be floor funding thereafter. In five or ten years, when there is pressure to pay for advanced and expensive treatments for life threatening diseases, how many PCTs will be able to resist the temptation to trim the dental budget. How many of us are prepared to borrow hugely, possibly using our own house as security, whilst using any minister's promise as our security?

PCTs do not always seem to be employing dentists best able to give them relevant advice. Whilst I was at the DPB, dental members of the Board were required by the DoH to receive the large majority of their earnings from the GDS.

The same requirement should apply to dentists advising PCTs on GDS matters. How many PCTs have adequate numbers of experienced staff capable of introducing on time, and then administering, the new arrangements? What is going to happen to our patients, our staff and us if they prove incapable of doing this?

But when is the proposed new contract to emerge? We need to be offered a fully priced contract by our PCT at least three months before the introduction of any change. Six months would be polite.

Solutions have to be provided in plenty of time to those problems many of us consider insoluble.

There need not be too much loss of DoH face, especially if we all agree not to say 'I told you so'. Some loss of face, however, would be appropriate for those responsible for introducing changes that I am very far from being alone in believing will make a sick GDS terminally ill.

C. H. Forsyth
Rutland
doi: 10.1038/sj.bdj.4811632

Antibiotic cover

Sir, we should no longer give penicillin cover to rheumatic fever patients and the like; such patients are five times more likely to suffer a fatal reaction to the antibiotic than they are to die of endocarditis.

These are the inferences I draw from the latest edition of *Evidence Based Dentistry* (*EBD* 2004, **5:** 46). It seems to me that it would be irresponsible, and risking litigation, to continue the established practice of giving the antibiotic cover. Are we all agreed on this?

G. Balfry
Bristol
doi: 10.1038/sj.bdj.4811633

Oral lichen planus

Sir, I am writing to ask if any dental practitioners have experienced any relevant link between oral lichen planus and the Atkins diet?

A middle aged female patient of mine, who has suffered from lichen planus of varying degrees over the last few years presented to me for a routine dental examination.

Surprisingly she informed me that her lichen planus had greatly improved over the last few months and this coincided with starting the Atkins diet.

Clinically, the lesions were much smaller and now asymptomatic, with some disappearing completely! However, the diet was stopped for a while and the

lesions and symptoms reoccurred.

Could this be another positive outcome for Dr Atkins? I'm curious if anyone else has had patients experiencing a similar pattern?

J. Wright
Deal
doi: 10.1038/sj.bdj.4811634

Plain common sense

Sir, a recent letter from Y. Maidment (*BDJ* 2004, **196:**662) suggested that there was some evidence that cycle helmets don't affect accident statistics and that therefore health care professionals including dentists should not promote them.

Isn't there a danger here of ignoring plain common sense? Recently I had a cycling accident. I hit my head on the road with considerable force. I was wearing a helmet that took the full impact, got up and walked away uninjured. When I consider the alternative of a major head injury, arguments of accident statistics seem strangely irrelevant. As a profession surely we should back a safety measure that so obviously makes sense?

R. Heathcote
Macclesfield
doi: 10.1038/sj.bdj.4811637

Patient confidentiality

Sir, as practitioners we are continually reminded of the need for patient confidentiality. Might I point out to colleagues who sit in judgement over others of the profession, the need for practitioner confidentiality.

Earlier this year on a train sitting opposite a tall gentleman, I found it wasn't too difficult to read the documents he was reading, albeit upside down, with details of a litigation claim, the dentist and patients and the solicitors involved. Joe Public may not know what LL4, RCT and BWs mean but others of us do.

J. Overmeer
Lochcarron
doi: 10.1038/sj.bdj.4811638

Risk management

Sir, the concept of risk management of problems is now in use throughout industry and is being developed in medicine.[1] In dental disease, risk management aims to identify the risk of an individual having dental problems from new disease or maintenance problems so that correct treatment can be given. This is particularly important for patients that travel to places where dental care is less accessible as shown by the following case.

A 22-year-old mechanic regularly worked in the Middle East for long periods. Prior to a trip he was seen for a routine dental inspection and reported no dental symptoms.

On examination considerable plaque deposits and food impaction were discovered between the partially erupted third molars and the distal aspect of the second molars.

This had been noted at a dental inspection two years previously but radiographs at that time had not shown any dental pathology.

New bitewing radiographs revealed dental caries in the distal aspect of the lower left second molar (Figure 1). All four wisdom teeth were extracted under general anaesthetic and the caries at the lower left second molar restored before his departure overseas.

As part of a risk management of dental disease a thorough assessment of third molar teeth is required. We would advocate in patients with partially erupted third molars that they should be questioned about any episodes of pericoronitis, and be given oral hygiene and dietary advice.

In patients without routine access to dental care where more than two episodes of pericoronitis have occurred, where oral hygiene is poor or the diet is high in sugar contents an expectant policy of 'wait and watch' to see if disease develops may not be appropriate.

We agree that the prophylactic removal of disease free wisdom teeth is not justified.[2] However, we believe more evidence is required to help quantify the risks to patients with infrequent access to dental care, of leaving partially erupted third molars in situ.

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A. M. Monaghan
A. J. Gibbons
By email
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1. Pronovost P J, Nolan T, Zeger S, Miller M, Rubin H. How can clinicians measure safety and quality in acute care? *Lancet* 2002: **363:** 1061-7.
2. The National Health Service Centre for Reviews and Dissemination. Prophylactic removal of impacted third molars: is it justified? Effectiveness Matters. 1998: **3(2):** 3.

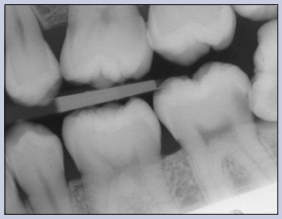

Figure 1: Left posterior bitewing radiograph