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

A retrograde step

Sir, we were interested to read the recent letter by Mr Hogg (*BDJ* 2005; **199**: 128) with regard to specialist dental training in the UK. He is clearly unhappy with the current situation, both in terms of the requirements for entry and the manner in which this training is carried out.

Current requirements for entry into specialist training have been identified and developed as the ideal, with input from a number of relevant bodies, not just the Royal Colleges of the United Kingdom.[1] A candidate should carry out a minimum of two years general professional training, in both primary dental care and the hospital or community dental service. This provides a platform for development of interests in specific specialities of dentistry and ensures the appropriate career progression, prior to specialisation. A broad understanding of clinical dental surgery also equips the future specialist with the necessary skills to undertake safe and comprehensive treatment within a specialist environment.

Far from being an 'intellectual mountain', the current MFDS examination is modular, accountable, clinically relevant and eminently passable. In does exactly what it was designed for – allows the candidate to demonstrate a broad knowledge of general dentistry prior to specialist training. The MFDS does not represent a repetition of undergraduate academic requirements and the idea that '90% of the profession' are unable to pass it is condescending to say the least. The concept that specialists are people that have 'fled' an unhappy life in general dental practice for the ivory tower of a dental school is not supported by the evidence. Taking our own speciality (orthodontics) as an example: we train a number of highly motivated individuals, the majority of whom go into specialist practice and provide the highest standards of patient care within the general dental services of the NHS. If so many specialists retreat into dental schools after qualifying, why is there a current crisis in the recruitment of dental academics?

Mr Hogg does suggest an alternative training pathway: entry requirements for specialist training should consist of some rudimentary clinical scrapbook that an individual has pasted photographs of a variety of restorations into over an undefined period of years, to demonstrate the full range of their clinical competence. This is then followed by two years of clinical training, spending one day a week in a specialist practice. We would argue that this is a retrograde step; education in a salaried position removes the commercial interest that can undermine training in practice. The two-year timeframe does not provide sufficient clinical exposure for specialisation. The majority of complex fixed appliance orthodontic treatments would be unfinished with such a curriculum, particularly as orthodontic specialists are undertaking clinical procedures that have not been experienced during undergraduate training.

Unfortunately, Mr Hogg wants it both ways; the opportunity to enter specialist training but without the inconvenience of taking any postgraduate examinations or a reduction in his material income while he is doing it. In reality, we do not believe that either is realistic or desirable in the interests of patient care.

M. Cobourne
D. Bister
F. McDonald
London

1. Faculty of Dental Surgery. *General professional training in England and Wales. A practical guide.* UK: Royal College of Surgeons of England, 2001.

doi: 10.1038/sj.bdj.4812978

Pacemakers and ultrasonic scalers

Sir, he risk to pacemakers from ultrasonic scalers is due to the magnetic field produced by the cable leading from the box to the handpiece. It is received wisdom that this risk is great enough that patients wearing such a cardiac control device are denied the benefits of ultrasonic periodontal treatment. In the absence of finding recently-published evidence to support this restriction I ask if any readers can provide an update on the position. It would be helpful to provide more than hand-scaling for pacemaker patients.

G. Balfry
By email

doi: 10.1038/sj.bdj.4812979

Motivated dental nurses

Sir, I was disappointed to read the letter from C. G. Buck (*BDJ* 2005; **199**: 317) describing some of the very badly worded performance criteria of the National Occupational Standards used in the Dental Nursing NVQ. It was just asking that candidates provide suitable information to patients, learn from experience, and be aware of our diverse society. That particular unit is common throughout all the health and social care qualifications and has recently been reworded. Several dental nurses (not surgery assistants) in my practice have taken the NVQ and I have been delighted with the extra skills they have developed, not least their awareness of the diversity and rights of our patients.

We have fortunately moved on from the days of an assistant at the chairside to well motivated Dental Care Professionals who wish a career in dentistry and contribute greatly to the efficiency and quality of the service provided by dentists. As Mr Buck said, there are a lot of 'part-time workers' in dentistry. I have five in my practice who have returned after career breaks because they had taken their qualifications and been motivated.

The first step in that career is undertaking a dental nursing qualification. Though there may be difficulties in some areas in accessing training, I would hope that as statutory registration by the GDC approaches, more resources will be made available to

support dental nurse training and their continuing professional development.

K. N. MacDonald
Stornoway
doi: 10.1038/sj.bdj.4812980

Respect for your team

Sir, oh for heaven's sake, will somebody please tell Dr Buck (*BDJ* 2005; **199**: 317) that the term 'DSA' hasn't been used for over 10 years.

Now Dr Buck has joined us in the twenty-first century, perhaps you could explain to him that the legislation he so fears covers the statutory registration, not examination, of dental nurses; that unqualified dental nurses can grandparent onto the new register, and that there are other examinations available to those who do take sufficient pride in their profession to want an actual qualification.

The key to recruiting and retaining competent staff is simple – treat them with respect as fellow members of the dental team and pay them a proper salary!

P. Swain
BADN Chief Executive
doi: 10.1038/sj.bdj.4812981

Pica and the palate

Sir, an interesting and enlightening article on pica from Dr Barker (*BDJ* 2005; **199**: 271-273) was spoilt by the fact that having surmised that the primary cause of tooth surface loss (TSL) of the lower incisors was due to the fractured and unglazed porcelain on the palatal surfaces of upper anterior crowns, the same destructive crown design was used for the definitive restorations. Metal palatal surfaces on maxillary incisor crowns are not only kinder to the opposing teeth but require less tooth preparation, are easier to construct accurately and to adjust on fitting. While we would all like to assume that our restorations will be more successful than the ones they replace, it is inevitable that they will fail eventually. When this happens in a bruxist, fractured porcelain surfaces of the anterior crowns will destroy lower incisors very quickly indeed. As we do not always know which of our patients are bruxists or will become bruxists, metal palatal surfaces of upper anterior bonded crowns need to be prescribed routinely.

J. Fleming
Cyprus

The author Mr Dean Barker responds: *I completely agree with Dr Fleming's sentiments in relation to the use of metal palatal surfaces on upper anterior crowns and concur that as a rule, this design of restoration should be considered in the first instance. However, as all experienced clinicians are aware, there are exceptions to any rule and I feel that this case represents one of them.*

Removal of the original crowns revealed the underlying teeth to have been very heavily prepared and therefore no further reduction of tooth tissue was required, other than minor modifications. In addition the relatively extensive use of porcelain allowed a better aesthetic result to be produced interproximally and at the incisal edge as translucency was introduced to the restorations.

I disagree slightly with Dr Fleming in that the inevitable need to replace crowns at some point in the future is more likely to be due to recurrent caries or aesthetic concerns related to gingival recession, rather than due to porcelain fracture, although I acknowledge that this was a risk in this individual patient due to the history of pica. It is the abrasive nature of porcelain that has been adjusted and not reglazed or polished sufficiently when fitting the crowns that is most responsible for wear of the opposing dentition. In this case, all restorations were produced on casts accurately mounted on a semi-adjustable articulator and no adjustment was required; if it had have been, the porcelain would have been reglazed. Furthermore, the restorations oppose composite rather than tooth tissue and indeed, due to the already destructive nature of the toothwear of the lower incisors, at no point will they contact dentine as should the composites fail, they will be replaced with further restorations of one form or another. To date there has been no significant wear of any of the restorations.

I am sorry that this issue spoilt Dr Fleming's enjoyment of the report, and I hope that these comments clarify my decision further.

doi: 10.1038/sj.bdj.4812982

Call for a vote

Sir, I would like to know why the BDA, which is the nearest thing dentists have to a union, is not going to ask its members to vote on the new GDS and new PDS contracts. When the government proposed a new GMS contract the BMA asked its members to vote on the proposed contract and in its original form the BMA members rejected the contract. The government did listen and change the contract. If I remember correctly, did a similar thing not happen with the new consultants' contract as well?

So, why if the new contract is so flawed don't we, the people who are going to have to work with it, get to vote whether or not to accept it and make the public and government aware of our voice instead of committees who do not represent the busy, hard working GDPs committed to the NHS? Or does the BDA not care about the NHS and is only interested in private practice?

S. Marshall
Heckington

Editor's note: *The situation faced by GMPs and GDPs with regard to their respective new contracts is not the same. The new GMS contract was available for negotiation before the relevant legislation was introduced. In the case of dentistry, the legislation came first and so the framework for the new contract was set and was never up for negotiation. In this issue's editorial, Lester Ellman explains the support the BDA is providing members at this crucial time.*

doi: 10.1038/sj.bdj.4812987

Disillusioned dentist

Sir, I realise that as a poorly educated GDP from the north east I may be confused, but after reading through the new draft proposals for GDS and PDS it seems that they are exactly the same! Not only that, but the need to hit a target level of UDA is without doubt the best description of treadmill dentistry ever. The changes to this profession over the last years have left me feeling increasingly militant and as such I have two questions. Firstly if I hit my target for UDA early, can I take the rest of the year off, or even better save that time for early retirement, and secondly as a profession why don't we stand up to the idiots in Whitehall and call a national strike? Amazing – hopeful graduate to disillusioned dentist in five years!

P. Woodhouse
By email
doi: 10.1038/sj.bdj.4812988

SCD status

Sir, I read with interest the letter from P. Erridge (*BDJ* 2005; **199**: 407-409), stating that: '*In some ways lack of a SCD specialty could be regarded as discrimination against people with disabilities*'.

Special Care Dentistry should also be valued for the unique contribution that it can make to improving other aspects of healthcare for disabled patients. Special Care dentists are potential leaders for other healthcare professionals, many of whom seem to find disabled patients both challenging and threatening. As a specialty, Special Care Dentistry will acquire the status that it deserves – a status that will also help to enhance the abilities of other healthcare professionals.

A. Tynan
Director, DIVERSE and LIVE! Fellow
By email
doi: 10.1038/sj.bdj.4812983