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E-mail 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

Manpower position

Sir, in his letter to the editor (*BDJ* 2005; **199**: 249), G. D. Woods rightly highlights that trainees in OMFS are not acquiring the necessary skills in surgical dentistry required for inclusion on the GDC's specialist lists. I have just completed an audit of treatment referral patterns into our OMFS unit and unsurprisingly have demonstrated that 80% of our workload is in surgical dentistry referrals. Bearing this in mind, G. D. Woods' comments also raise clinical governance concerns for a future service that is supposed to be consultant led with those consultants lacking proficiency in this clinical field.

I have been involved in the OMFS 'Registrar in Training Assessment' (RITA) processes over the last number of years and I too have been concerned that OMFS units are failing to deliver appropriate training and clinical experience in surgical dentistry for their OMFS registrars. Not only should the GDC consider excluding future trainees in OMFS from the oral surgery/surgical dentistry specialist lists but the Department of Health needs to re-evaluate its manpower position and ensure that consultant oral surgeons/surgical dentists are introduced to guarantee that clinical services have the most appropriate consultant to lead them.

L. W. McArdle
Edinburgh
doi: 10.1038/sj.bdj.4813134

Dumbing down dentistry

Sir, some years ago (1990/92) when dentistry was in crisis the *BDJ* published a letter from me under the headline *No alternative*. The letter was copied, dissected and discussed by many of the dental papers at the time. The situation has not changed and the sentiments expressed then are still valid. There is one change however in that I am now retired from general dental practice. I made the changes that my bank manager urged and enjoyed a hard working but moderately rewarding final decade in dentistry. The previous 27 years, utterly committed to the NHS GDS, had become increasingly dire.

The GDP of today owes nothing to the NHS. The GDS owes today's GDP for the infrastructure that s/he has provided, also for the employment of staff and the business risks taken. The GDP of today needs to be at least as 'businesslike' as the NHS authorities. Indeed the NHS expects him to be so and loads him with debts and responsibilities. Placing the NHS logo on a document does not sanctify it.

GDPs can expect a real reward for their efforts, not a formulaic obfuscation that hides the truth. The nGDS Draft Contract is built upon the 'discredited' formulae of the past and is therefore of little use to GDP or their patients. The treadmill has not been removed, just disguised. If implemented nGDS will define what dentistry is for a generation to come and thereby dumb down British dentistry and move it even further from First World norms.

I urge GDPs to grasp the nettle and take their own, their families' futures and their patients' welfare into their own hands. Difficult decisions will need to be taken whether 'to stay' or 'not to stay'. Whether they wish to run a charity or a business must be decided. Change is in the hands of every practitioner, not just in the un-negotiated edicts of DoH.

C. Bosley
Oxford
doi: 10.1038/sj.bdj.4813135

Restrain or refer?

Sir, we have recently completed an evaluation of a series of patients referred to a child and adolescent mental health service (CAMHS) for dental phobia and would like to share some of our findings with your readers. At the assessment interview, one child described being physically restrained during previous dental work. The others all described an experience of an adult they perceived they could not challenge drilling in their mouth. It seemed surprising that physical restraint had been used and I discussed this with the local community dental officer (CDO.) She reported that 'a fair proportion' of children referred to her with high levels of anxiety or phobia recalled an episode of physical restraint. A questionnaire was then sent to local dentists (n = 96) to determine the prevalence of restraint and other types of control techniques being used for anxious or non-compliant children.

Over 80% of dentists responded to the questionnaire, with 25% reporting that they asked family members to restrain children by their shoulders or arms (half used this technique at least each month) and 19% reporting that a member of the practice staff had been used to restrain the child (one third of these at least monthly.)

We were encouraged to discover that all those who completed the questionnaire used less threatening anxiety management techniques before restraint, such as distraction, counting through the procedure, and multiple appointments to put the child at ease. Unfortunately time and commercial pressure can limit the use of lengthy anxiety management techniques. Until recently, sedation or general anaesthesia was an option for these children, however the 2001 General Dental Council guidelines stated: 'A dentist who makes a decision to refer a patient for sedation without first exploring all aspects of pain and anxiety control is liable to a charge of serious professional misconduct.' This may be a factor leading to the use of restraint, but it is important to note these guidelines also stated: 'There can be no justification for intimidation, or, other than in the most exceptional circumstances, for the use of physical restraint in dealing with a difficult patient.' The recent revision of these guidelines in May 2005 is much less prescriptive and does not explicitly mention restraint. However the principles of dignity, choice and consent are highlighted and it is to be expected that all professionals would consider these in the treatment of every patient, including those under 18 years of age.

In view of these guidelines, and the extent of restraint use, it may be that one solution lies in increased training for dentists or joint working between dentists and CAMHS. This would facilitate more use of specialist anxiety management. Any resource and funding implications from an increase in the number of children referred to CAMHS would need monitoring, but it is not unreasonable to hope that these could be negotiated if it was deemed necessary to prevent children being restrained or sedated in breach of guidelines. It may be helpful for a named link worker from the

local CAMHS team to work with CDOs and offer training and joint working.

There may be services that already have experience of joint working and it would be interesting to hear from them. Dentists working within such a service may find it helpful for planning treatment and maintaining therapeutic relationships with children.

In closing, we would like to thank Judith Bray, community dental officer, for her help in this work.

L. Brunt
B. Wright
York
doi: 10.1038/sj.bdj.4813136

The *BDJ* is 134

Sir, it is good to see the current series of articles by Professor Stanley Gelbier covering the amazing progress of some of the aspects of dentistry over the last 125 years, many of which we take for granted (*BDJ* 2005; **199**: 389-395).

However, the truth is, as instilled into me by my predecessor and former curator of the BDA museum, Mr Archie Donaldson, the journal published by the BDA is older than the Association because it is 134 years old. The reason is that when the BDA acquired the title *Monthly Review of Dental Surgery* in January 1880, it did not alter the previous publication's volume numbering and boldly stated that the journal was in its ninth year of publication. Fortunately, the confusion was dispelled when it was decided to renumber the April issue Volume 1 Issue 2 and incidentally at the cover price of 6 pence!

It may be of further interest to know that the original intention of the founders of the BDA was to purchase the prestigious *British Journal of Dental Science*. This had already enjoyed success for 24 years under the owner-editorship of Charles James Fox, who had not only espoused the cause of the College of Dentists but also campaigned for compulsory education and registration in the 1870s, ideals favoured by the Association's founders. It was because negotiations to purchase this journal failed that they turned their attention to the *Monthly Review of Dental Surgery*.[1]

M. Seward
Former Editor, *BDJ*
Bournemouth

1. Seward M H. Proper words in proper places. *Br Dent J* 1992; **1**: 24-30.

Professor Gelbier responds: *Thank you for the opportunity to respond to Dame Margaret's letter welcoming my series of historical articles. Of course she is correct in the historical detail. Readers might like to know that my original draft title was indeed 134 years of developments in dentistry. However, I decided to change it to 125 years because that accurately reflects the time span of BDA ownership of the journal. Nevertheless my article confirms that both a journal (*Monthly Review of Dental Surgery*) and the title of* British Dental Journal *preceded 1880. I look forward to seeing other points of clarification from readers about events featured in the series.*

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Encouraging prognostic sign

Sir, I read with interest the article on paraesthesia of the lip and chin area resolved by endodontic treatment (*BDJ* 2005; **198**: 743) and do compliment the authors. I feel it is useful for oral surgeons to be reminded, occasionally, that their services may not be required, even when the initial radiolucency is of significant size.

I was particularly interested in the series of radiographs (Figs 1-3) for again this reminds us that, even before there is definite proof of developing bony regeneration, a re-approximation of displaced roots occurs. This can be an even sooner encouraging prognostic sign.

B. Littler
Chelmsford
doi: 10.1038/sj.bdj.4813138

Outside the box

Sir, for more years than one might care to recall, John Mew has performed the valuable role of Agent Provocateur to the orthodontic specialty.

The sight of a free intellect, thinking outside the box and unafraid to say so, is magnificent indeed, if only for the spectacle of the weight of retribution that falls on him.

In truth, few rational people could object to much in his recent opinion article in the *BDJ*.

It has long been obvious that malocclusion, like asthma and diabetes, is a disease of modern civilisation. Primitive man did not suffer from it, yet it is so common these days as to be almost 'normal'. Soft food and a congested upper airway are, without doubt, the prime aetiological factors in modern day crooked teeth.

Yes, there is a variable genetic susceptibility but it is just that – a susceptibility to those causative environmental factors, without which there would be no disease. It is the narrow maxilla that these factors produce, that crowds the teeth and holds back the developing mandible.

The above seems so self evident, that one wonders why it could be controversial. However, all times have their orthodoxy – blood letting in the Middle Ages, leeches a while later – and significant shifts in the accepted 'truth' only ever come from those who think outside that which is considered acceptable. Hence the value of John Mew and those like him.

D. Horobin
By email
doi: 10.1038/sj.bdj.4813139

No miracles

Sir, I read with interest the recent thought provoking opinion article by J. Mew (*Br Dent J* 2005; **189**: 495-497). In this article, Dr Mew argues the relative merits of science versus empiricism in both the causes and the treatment of malocclusion.

I disagree with Dr Mew in that optimal orthodontic care is actually delivered by clinicians who combine knowledge (science) and experience (empiricism) in routine clinical practice. This is of particular relevance in the main theme of Dr Mew's article – 'growth guidance'.

A recent MEDLINE search produced 1,915 hits when the search term 'Orthodontic Appliances, Functional' was used. Of these, the randomised controlled trials[1-5] (in addition to a multitude of other studies [of variable quality]) have all failed to produce any evidence that 'growth guidance' produces any significant 'extra' anteroposterior mandibular skeletal growth in Class II cases. Similarly, there is no evidence that any orthodontic appliance can convert vertical skeletal growth into horizontal skeletal growth. Nonetheless, all orthodontists have experience of cases where useful skeletal growth coincides with the wear of the 'growth guidance' appliance. However, 31% of the untreated controls in one study also grew favourably.[6] There are also many 'growth guidance' cases where the outcome is not successful for a variety of reasons.

These facts do not diminish the value of empiricism in clinical orthodontics, but if we fail to combine the substantial amount scientific evidence with clinical experience, we are misleading both ourselves and our patients. How much more evidence is needed to convince the dental profession that 'growth guidance' appliances do not produce a miraculous change in skeletal growth?

G. T. McIntyre
By email

1. Jakobsson S O. Cephalometric evaluation of treatment effect on Class II, Division I malocclusions. *Am J Orthod* 1967; **53**: 446-457.
2. Keeling S D, Wheeler T T, King G J *et al.* Anteroposterior skeletal and dental changes after early Class II treatment with bionators and headgear. *Am J Orthod Dentofacial Orthop* 1998; **113**: 40-50.
3. Ghafari J, Shofer F S, Jacobsson-Hunt U *et al.* Headgear versus function regulator in the early treatment of Class II, division 1 malocclusion: a randomized clinical trial. *Am J Orthod Dentofacial Orthop* 1998; **113**: 51-61.

4. Tulloch J F, Proffit W R, Phillips C. Outcomes in a 2-phase randomized clinical trial of early Class II treatment. *Am J Orthod Dentofacial Orthop* 2004; **125**: 657-667.
5. O'Brien K, Wright J, Conboy F *et al.* Effectiveness of early orthodontic treatment with the Twin-block appliance: a multicenter, randomized, controlled trial. Part 1: Dental and skeletal effects. *Am J Orthod Dentofacial Orthop* 2003; **124**: 234-243.
6. Tulloch J F, Phillips C, Proffit W R. Benefit of early Class II treatment: progress report of a two-phase randomized clinical trial. *Am J Orthod Dentofacial Orthop* 1998; **113**: 62-72.

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Exercising the tongue

Sir, J. Mew has been giving the orthodontic world and the general population his opinion now for a number of years, in the dental press, the national newspapers and even on television. This can be condensed down to two things, that most orthodontists are damaging patients' faces and that they would not do so if only they adopted Mr Mew's treatment ideas. Not content with inventing a new brace he has to invent a new treatment, not orthodontics but orthotropics.

So, yet again, another opinion piece in the October issue, called *Science versus empiricism*. After reading this confusing article one is no nearer understanding what Mr Mew's orthotropics is or does. What orthotropics seems to be, although this is not clear, is the use of functional appliances with added tongue exercises. Since most orthodontists use functionals, and tongue exercises are likely to have no effect then one can only assume that he is doing the same as everyone else. The problem is that Mr Mew has a theory but nothing else to back it up. Therefore can I please ask of Mr Mew three things: 1) stop proclaiming how right you are, we get the message but I'm afraid it will be ignored until you, 2) publish the details of your orthotropic treatment so we can actually find out what it is, a suitable title would be Orthotropics a step-by-step guide (please don't suggest that I could join the London School of Orthotropics to find out) and last but by no means least, 3) publish some evidence that it works, a double blind clinical trail would be nice but even an audit of 50 sequential cases would do as a start. You may be able to convince a few non-sceptical individuals that you are right but most of us are not prepared to ask our patients to do tongue exercises when they are likely to have no effect and neither should you. I am constantly disregarding treatments that are overcomplicated and work no better than the simple ones, why not give it a go, you may be surprised.

A. Pearson
Oxford
doi: 10.1038/sj.bdj.4813141

The burden of proof

Sir, most people in orthodontic and dental practice will be aware of Dr Mew's beliefs (*BDJ* 2005; **199**: 495-497) and I have resisted responding to them in the past to avoid adding fuel to the fire. I feel however I have to respond to his latest article in the *BDJ*, not on the grounds of the comments he makes about orthodontic practice but his misuse and obvious misunderstanding of the concepts of empiricism.

A central concept in the philosophy of science is empiricism, or dependence on evidence. Empiricism is the view that knowledge is derived from our experience throughout our lives. In this sense, scientific statements are subject to and derived from experiences or observations. Scientific hypotheses are developed and tested through empirical methods consisting of observations and experiments. Empiricism therefore has been a cornerstone of all science from the Enlightenment to the modern day and is the process whereby theories are tested and science advanced. In the medical and dental sciences this would be part of the concept of evidence-based practice.

Just because the current evidence refutes Dr Mew's claims of growth guidance does not mean he can dismiss it as not being science. In fact the reverse is true. His views that are based on deductive logic are the ones that fail to stand up to the objective rigours of empirical investigation. The problem with any form of logical argument is that it has to be based on assumptions or premises that are true. Dr Mew's premise is that the cause of malocclusion is environmental or more specifically poor oral posture. He therefore argues that if oral posture is corrected malocclusion can be cured. However, the aetiology of malocclusion is poorly understood and all we can say at this stageis that it is certainly multifactorial. Therefore his premise is based on personal opinion and is certainly not a scientific truth. As such the whole of his argument is far less scientific than the empiricism of current research evidence that he constantly decries.

Francis Bacon, one of the great empiricists, who set the stage for modern science, warned us to be wary of the 'idols of the mind' and teachings based solely on words and personal opinion. As before the burden of proof remains with Dr Mew, and in future if he is going to use big words to try and impress us he should really understand what they mean.

A. Di Biase
Kent
doi: 10.1038/sj.bdj.4813142

Skulduggery in the NHS

Sir, I recently attended a course at the Plymouth Hoe Moat House entitled 'Hot Topics in Today's Dentistry' which turned out to be some sort of damage limitation exercise on behalf of the government in which Kevin Lewis and Raj Rattan regaled us with contrapuntal lectures on what a splendid future the NHS had to offer us all.

As a practitioner without any NHS patients at all, I was a little bemused by this unexpected softening-up exercise but sat out most of it anyway. When I opened the deeper layers of the nice cardboard folder we all were given I discovered my certificate of attendance was for a course entitled 'Business Opportunities in the New NHS'. So THAT'S what I went to!

I laughed all the way back to the car.

Is it significant that such a level of skulduggery is now needed to catch the ear of the hordes of GDPs who want nothing more to do with their system?

J. G. McLaughlin
Devon
doi: 10.1038/sj.bdj.4813143

BADN membership

Sir, it has come to our attention that a number of dentists have been paying, on behalf of their dental nurses, for a subscription to a new dental nursing magazine under the misapprehension that this will entitle the dental nurses concerned to the benefits of British Association of Dental Nures (BADN) membership.

While BADN is happy to provide this magazine with both articles and a representative to its Editorial Board, the Association has no commercial or financial connection with the magazine or its publishers, and does not in any way profit from the money paid in subscriptions. Taking out a £50 annual subscription to this magazine does not, therefore, confer BADN membership with its accompanying benefits.

BADN membership currently costs £37 per year (although there are lower rates for students, part-time workers, etc) and, in addition to our own quarterly *British Dental Nurses' Journal*, entitles dental nurse members to a wide range of benefits – including free legal advice, support, advice and information on a wide range of topics These include health and safety advice sheets, a free CD-Rom full of information, articles and advice, and discounts on a wide range of products and services – from home, car and travel insurance through holidays to high street items such as DVDs and videos, as well as health care, eye care, fitness clubs, dental nurse textbooks and magazine packages for the waiting room. BADN also has a network of National and Local Groups which offer Continuing Professional Development through a series of Study Days available at discounted rates to BADN members. The membership fee is tax deductible.

Employers may obtain membership application forms by contacting BADN on 01253 338360 or by emailing admin@badn.org.uk.

P. Swain
BADN Chief Executive
doi: 10.1038/sj.bdj.4813144

Women in practice

Sir, I feel your correspondent (D. Thomas *BDJ* 2005; **199**: 545) has an over simplistic view of the role of women in the dental manpower shortage.

The figures quoted indicate that there are higher numbers of younger practitioners amongst women compared with men, ie women at a stage when they may prefer to work reduced hours. As time progresses, the proportion of women working fewer hours than men may well change as women without pressing family commitments increase their hours at the same time as the increasingly older men 'wind down'. The under representation of women in practice ownership, involvement in postgraduate training and policy making bodies probably indicates that they are spending a larger proportion of their (albeit reduced) working hours involved in delivering patient care.

For the record, I am a married woman with teenaged children who has worked full time in the NHS since qualification more than 20 years ago.

C. Cripps
doi: 10.1038/sj.bdj.4813145

Antibiotic prophylaxis: a myth?

Sir, I would be grateful if you could enlighten me on a topic that is causing me great concern. I encountered a patient recently who is 31 years of age. She is a single mother with four children. She has been to the dentist throughout her life for dental treatment. In the past she has had 11 adult teeth and numerous primary teeth extracted at different times. She has had countless scalings and root planings with conscientious dental practitioners following periodontal assessments with a periodontal probe. These episodes have taken place at different times from childhood to date. At present she has active decay in at least four teeth and she suffers from generalised chronic adult periodontitis. Her oral hygiene is poor and tooth brushing leads to profuse gingival bleeding.

Recently, after the birth of her fourth child she suffered a stroke. Further investigation revealed that she had a patent foramen ovale of which she had no prior knowledge. The recent guidelines indicate that a patent foramen ovale is a moderate risk factor for bacterial infective endocarditis.[1] A patent foramen ovale can cause severe turbulence of blood flow causing damage to the endothelium which in turn increases the likelihood of forming a thrombotic vegetation. Bacteraemia from a dental procedure may lead to seeding of the vegetation and thus symptoms of infective endocarditis. As a moderate risk factor for causing IE, dental procedures such as extractions, sub gingival debridement, scale and polish, and periodontal probing all require antibiotic prophylaxis according to recommendations from groups such as Medical Practice Committee of the British Cardiac Society, the Faculty of Dental Surgery of the Royal College of Surgeons of England, the Society of Cardiothoracic Surgeons, and the Working Party of the British Society for Antimicrobial Chemotherapy.[1-3]

The fact that this patient had a patent foramen ovale was not known to anyone and only came to light after she suffered the stroke, as mentioned above. Therefore, no antibiotic prophylaxis was given to her for any of her at risk dental treatment procedures at any time throughout her life. However, she suffered no ill health at any time after her dental treatments throughout her life. Similarly there have been incidences where patients receive antibiotic cover for congenital heart conditions during dental procedures but still suffer from infective endocarditis.[4]

This has caused me to speculate whether antibiotic prophylaxis is necessary for this congenital heart condition and similarly perhaps some other congenital heart conditions. Had her relevant medical history been known she would have received numerous doses of antibiotic prophylaxis. I wonder if my experience is coincidental or have my learned colleagues had similar experiences? By giving antibiotic prophylaxis where there is no need are we increasing the likelihood of antibiotic resistance? It begs me to ask the question, am I doing the best for my patients by giving prophylaxis for such congenital heart conditions or do the guidelines need to be re-evaluated? In this evidence based medicine era are we practising evidence based dentistry?

A. Korada
Newcastle upon Tyne

1. Dental aspects of endocarditis prophylaxis: New recommendations from a Working Group of the British Cardiac Society Clinical Practice Committee and the Royal College of Physicians Clinical Effectiveness and Evaluation Unit. 19 April 2004 www.rcseng.ac.uk.
2. Clinical Affairs Committee. Clinical guidelines on antibiotic prophylaxis for patients at risk. *Ameri Acad Pediatr Dent* 2004; **26**: 142-143.
3. Ramsdale D R, Elliot T S J, Wright P et al. Guidelines for the prophylaxis and treatment of infective endocarditis in adults. http://www.bcs.com 2004: 1-106.
4. O'Sullivan J, Anderson J, Bain H. Infective endocarditis in children following dental extraction and appropriate antibiotic prophylaxis. *Br Dent J* 1996; **181**: 64-65.

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