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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

Don't be put off

Sir, I am a dentist, qualified King's College, London 1990. I am also a doctor, qualified Cambridge 2001.

I read Dr Westcott's letter (*BDJ* 2006; 200: 125) with great surprise. The Cambridge system for the uninitiated is a little complex; I wonder sometimes if your capability and determination to find your way through it may be a part of the selection procedure! However, to say that Cambridge does not welcome applications from dentists is a complete fallacy.

I was in the unique position of being part of two cohorts of postgraduate students while I read medicine; I was, and still am, a keen sportswoman and took time out to concentrate on my sport. When I first started there were, if my memory serves me right, six postgraduate students in my year of about 200 students who started the Tripos (the Cambridge pre-clinicals). Of these three were dentists. In the second cohort I joined there were again six postgraduate students out of 130 clinical students; of these two were dentists. I am sure your readers will agree these are not bad odds given that Cambridge is in a position to pick 'the cream' of postgraduate applicants. It is important to realise, however, that if you want to apply to read medicine as a graduate, and have not completed an undergraduate degree at Cambridge, you need to apply to either Lucy Cavendish (women only) or to Wolfson (men and women), the latter being my old college. These colleges are very restricted on how many postgraduate students they can accept onto the medical course so competition is very tough!

Does Cambridge accept 'other' degrees? If you are expecting to get 'time off' due to what you have done before, forget it. As a graduate student you are allowed to miss out the otherwise compulsory intercalated BSc but other than that you must complete the whole course which is separated into pre-clinical and clinical. In fact one of the postgraduate medics I knew had a first in biochemistry from Oxford but was still required to take the pre-clinical biochemistry course and examination! This may sound strange but it is the Cambridge way – maybe their rationale is that unless you have attained your first degree at Cambridge they do not really know the extent of your knowledge and therefore feel it is better to ensure everyone goes through the complete system to be sure the academic exit criteria are met.

Are Cambridge open to 'unusual' applicants? I am indeed an unusual applicant! I read medicine in order to follow a training pathway in anaesthesia in order to specialise in sedation, having come from a background of dental sedation. I never wanted to be a maxillofacial surgeon and although I do have a masters in dental anaesthesia I do not have FDS; when I looked at other medical schools most required FDS so Cambridge was far more flexible in this respect. I can safely say that the interview process was the toughest I have ever experienced but what the admissions tutor and interview panel want to assess is not just what paper qualifications you have but how you think, and whether you can think and reason 'on your feet'. In this respect they are very 'open' as regards whom they offer places to – in fact one chap in my year who read veterinary science was in his late twenties when he started and had been a commercial diver and a tree surgeon before! Another, reading philosophy, had been a Tornado fighter pilot in the RAF!

I think Cambridge is a wonderful academic institution which offers a truly fascinating and unique experience and would strongly recommend it to anyone wanting to spend time at university. I would also say to dentists wanting to read medicine, do not be put off by the 'unusual' system and the tough competition; from my own experience you actually have a better chance of getting in than most other postgraduate applicants!

A. Wraith
By email
doi: 10.1038/sj.bdj.4813529

DIY dentistry

Sir, we saw a 40-year-old male heavy goods vehicle driver of middle class background via an access centre in Airedale Primary Care Trust complaining of dental pain in his upper left quadrant. His medical history was clear, his periodontium healthy and he had last visited a dentist some four to five years previously, since when his general dental practitioner (GDP) had discontinued NHS dental services and the patient could not afford private dental care. Despite multiple attempts he could not re-register with another GDP.

The patient had suffered severe pain occurring randomly, lasting between 30-60 minutes, which could not be localised, with associated sleeplessness for the previous two nights. However, he disclosed that he knew exactly the tooth which could be the culprit, since he had a history of a lost restoration in the upper left seven (27) three years previously with minimal discomfort. The tooth had been treated twice in the past three years, by the patient himself!

On questioning he revealed that to debride the cavity he used a holiday-dental-kit comprising of plastic mirror, forceps and probe combined with an electric toothbrush with a small round head. For convenience, the patient had trimmed the bristles to fit into the cavity. He had used tactile senses for plugging the filling material into the prepared cavity, using a material called Quick Steel™ (Fig. 1) bought from a DIY motorcar parts retailer. Clinical examination revealed the skill with which the patient had maintained this self-applied restoration (Fig. 2) for over two years.

On investigation the tooth had classic symptoms of irreversible pulpitis and a radiograph revealed a very deep restoration with possible pulpal involvement but no obvious periapical pathology. According to the patient, since the loss of the DIY restoration the self-debridement of the cavity had been aggressive and may have been enough to cause an exposure and symptoms of

pain. It is impossible to confirm whether the exposure was due to gradual progression of caries or was self-inflicted. The patient decided to have the tooth in question extracted under local anaesthetic, as he was unable to seek continued care for it elsewhere. However, recently he has registered with a GDP in the local area under the NHS scheme.

The instruction leaflet clearly stated that Quick Steel™ was dangerous to ingest, and the patient revealed that he was fully aware of the unsuitability of this product for intra-oral use. However, as his father owned a motorcar garage, he had been familiar with the material for a long time and chose it because of its easy workability, mechanical properties and its rock hard set after kneading. The tensile strength (TS) of this material is 4.1MN/m2 which is comparable to zinc phosphate[1] and its compressive strength (CS) is 12.41MN/m2 which is closer to the CS of zinc oxide-eugenol.[1] This case report clearly reflects the national shortage of NHS GDPs and the bizarre lengths that patients go to in order to have dental treatment.

S. B. Misra
K. J. Toumba
Leeds

1. Combe E C, Grant A A. Physical and mechanical properties of dental materials. *In*: *Appendices of notes on dental materials.* (6th edn.) pp 233-234. UK: Churchill Livingstone, 1992.

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Fig. 1
Quick Steel™

Fig. 2 UL7 (27) post-extraction

Unseen evidence

Sir, I welcome the article by Farrier *et al.*[1] as it is a reminder of the importance of eye protection in dental practice. However, a similar paper was published in the *BDJ* by my brother (an ophthalmic surgeon) and sister-in-law (a dentist) in 1991,[2] which is not referenced by the authors. This is a pity because although published some years ago there are striking similarities between the two papers. Of course there is nothing wrong with this as similar studies add to the weight of scientific evidence, but a comparison of the two papers would have been useful because sadly, in the 15 years between the publications, there has been little improvement in either the level of eye protection, or in the incidence of ocular injuries within the dental team.

D. Roberts-Harry
Harrogate

1. Farrier S L, Farrier J N, Gilmour A S M. Eye safety in operative dentistry – A study in general dental practice. *Br Dent J* 2006; **200**: 218-223.
2. Roberts-Harry T J, Cass A E, Jagger J D. Ocular injury and infection in dental practice. A survey and a review of the literature. *Br Dent J* 1991; **170**: 20-22.

doi: 10.1038/sj.bdj.4813531

Ethical marketing

Sir, I read the letter by Atkinson *et al.* (*Commercialism in marketing*, *BDJ* 2006; **200**: 124) with a mix of pleasure and concern. First, before explaining myself further I must state that I agree completely with the sentiments of the letter. It is the final paragraph in the letter (which calls for a debate on whether the current methods of marketing dentistry to patients is beneficial to patients) that concerns me. It makes me wonder whether a true understanding of the process of marketing and the benefits this can bring to both patients and profession will ever be realised.

The reason that I was pleased by the letter is simply that it is so satisfying to see the subject of dental business raising its head again in the *BDJ*. I was also pleased to see that initially the authors distinguished in their letter between the process of marketing and the use of promotion, as so often the terms 'marketing' and 'promotion' are used as if they are synonymous. But, having initially made the distinction the authors then appear to forget this in their final paragraph. Surely, if calling for a debate the authors should have used the term 'promotion' so that their letter would call for a debate on 'Are the current methods of promoting dentistry by dentists *beneficial to patients* (my emphasis) and do they enhance the reputation of the profession in the public's eye?'.

Marketing, when carried out ethically, is 'the process of identifying, anticipating and satisfying patients' (customers') requirements profitably'[1] and is something that dentists have been doing as part of their consultation, examination and treatment process for decades. This involves finding out what people need and want (market research); anticipating what you think they will want or need; developing the product or service to satisfy that need or want; telling people about it (promotion) and ensuring the whole process is profitable (in other words that enough people will buy it). This process is very similar to the traditional model of providing healthcare.

In contrast unethical marketing is trying to persuade people to buy what you want to sell them (even if you sincerely believe it is for their own good).

In my opinion where we as a profession have fallen down in the past is in the truly ethical process of market research. Rather than trying to find out what people really need and want in terms of dental care we have assumed we know what is best for them and then tried to persuade them to buy it. We call this process 'health promotion'. In other words we have behaved more like people carrying out unethical marketing, albeit with the best of intentions.

While I am in agreement with the authors of the letter that we should indeed be debating the more unethical promotional techniques by dentists that we see in the media and elsewhere, perhaps we also need to expand the debate further and look at how we (as a profession rather than individually) should be pursuing a more ethical approach to marketing overall.

M. Grace
By email

1. Definition of The Chartered Institute of Marketing.

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Verbal dilemma

Sir, I have been fascinated by a boxed advert that often appears in your journal asking me if I have a 'foreign accent' and whether I would like an 'English accent' (being taught by post??).

English is not my first language but I have survived for a decade in the UK working in NHS hospitals. Having moved from Scotland, through the north of England down to the West Midlands and finally being based in Wales, I have come across so many variations in the English (?) accent that I wonder which one is actually the one on offer – would it be Glaswegian, Black Country or the plain and simple Swansea accent with the 'innit' thrown in for added effect?

Personally, I feel I would be comfortable with the Eastenders accent as I have watched the soap as a part of my efforts to 'integrate'.

I am in a dilemma here. Perhaps your readers may be of some help in this matter and help me make up my mind.

J. Chandrasekhar
Neath
doi: 10.1038/sj.bdj.4813533

Farce and fiction

Sir, C. McCanny's letter (*BDJ* 2006; **200**: 123) implies, rather unkindly I thought, that Mr Mew's beliefs are fictional.

How farcical then to suggest bringing NICE into the equation; it could only make matters worse as the 'Clinical Excellence' part of their title is the greatest fiction of all.

L. J. Brinton
Suffolk
doi: 10.1038/sj.bdj.4813534

Dubious diagnosis

Sir, I would like to bring to your attention the published article *Concrescence of a mandibular third molar and a supernumerary fourth molar* (*BDJ* 2006; **200**: 141–142).

This case report suggests that the third molar was extracted due to intermittent pain experienced by the patient. Upon careful examination of the published radiographs, I have come to the conclusion that the tooth is fully impacted and shows no evidence of infection. The clinicians have failed to notice the deep occlusal and proximal caries lesion associated with 7 which I think is the cause of the symptoms experienced by the patient.

Although the article summarises concrescence of wisdom teeth, it fails to establish a proper diagnosis for the patient's chief complaint (pain). Instead of treating the symptomatic lower right second molar, the lower right third molar and the supernumerary fourth molar were surgically extracted. The above extractions are not compliant with NICE guidelines – which highlights the importance of arriving at a correct diagnosis.

S. Paripaty
Cambridge
doi: 10.1038/sj.bdj.4813535

3D anatomy online

Sir, Senior House Officers in oral and maxillofacial surgery may be interested to know that they can access an online 3D anatomy service (www.anatomy.tv) by registering for free with Univadis at www.univadis.co.uk.

The website makes anatomy revision interesting and interactive, allowing the layers of the head and neck to be peeled back layer by layer. The image can then be rotated and magnified as required. MRI views and MCQs are also available to test what has been learned. The Univadis website offers other services besides this and is well worth a visit.

Please note that although the registration webpage asks for a GMC number, Univadis does offer membership to singly qualified dental surgeons working in the hospital service.

J. V. Williams
Cambridge
doi: 10.1038/sj.bdj.4813536

A bit fishy

Sir, I was saddened to see recently on 'Who Wants to Be A Millionaire' that a singly qualified 'oral surgeon' failed to answer a question on the vitamins in Cod Liver Oil, a topic well covered in undergraduate medical courses. Another argument for dual qualification?

P. Magennis
Liverpool
doi: 10.1038/sj.bdj.4813537

Bailing out of academia

Sir, I read the call-to-arms of Professors Kay and O'Brien (*BDJ* 2006; **200**: 73) with interest and hope that many fresh faced academic recruits answer it. What with 'time', 'support' and 'secretaries and administrators to help you do your job', life must indeed be rosy in Manchester! I agree there is 'immense value and joy' in an academic career, so why are clinical academics bailing out? Here are some possible reasons:

Service, research and teaching are not just 'competing pressures', they are each potentially full-time occupations in their own right. Yes, there are a few very talented individuals who are able to excel equally at all three, but even the brightest do not achieve it in a 40 hour week. Yet this is all the universities are prepared to pay for. The NHS will offer the same, and often better, for just the service component.

'To pursue and research the things about your profession which most interested you'? Well, let's hope so, but the new recruit will find him/herself allocated to a research group contrived for the purposes of the Research Assessment Exercise (RAE) and may have little freedom in choosing a research topic. The RAE should be an opportunity for the universities to showcase their achievements. However, the financial goalposts are not set until after the returns have been made, and so dental schools are obliged to devote precious manpower and time resources

to working out how best to 'play' the system in order to achieve a high rating.

The list of RAE assessors for dentistry is, not surprisingly, comprised of academics pooled almost exclusively from dental schools. Why, then, allow academics from elsewhere within the university, usually the adjacent medical school, to co-ordinate a dental school's RAE return? These individuals know little, if anything, of the demands of dental academia, may have minimal clinical and teaching commitments themselves, and perceive that research not published in mainstream science and medical journals is of poor quality. Actually, in 2004 the impact factors of 14 dental journals were higher than 1.5, and in seven it was 2.0 or above.[1]

As a clinical academic I am obliged to produce four papers that are deemed to be of adequate quality for the RAE. Not an unduly burdensome load, if protected time for research has been provided. In my NHS post I elect to do research if I wish, am spared the patronising, pre-RAE interview with the co-ordinator with no knowledge of my field, and improve my chances of a Clinical Excellence Award!

Excellence in teaching, as in research, is supposedly recognised as a means to promotion, but is this really the case? While not wishing to encourage these paper chases, the first, and so far the last, assessment of teaching quality was carried out in 1999. The 2008 RAE will be the sixth.

Some suggestions, therefore, none of which will ever happen:

- With the recent announcements of new undergraduate places, the Government has recognised the nation's dental schools are a valuable resource and, as Kay and O'Brien point out, dental academics have the 'considerable political muscle' of 474 established posts. Therefore, establish dental schools as separate faculties, rather than annexes of medical schools;
- Refuse to co-operate with the RAE until the funding consequences are known;
- Failing that, ensure that preparation for the RAE is conducted by someone at least vaguely acquainted with the realities of dental academia;
- Ensure high productivity (in either teaching, research, service or a combination thereof) is accurately reflected in pay and conditions, not only for clinical academics, but also for non-clinical and preclinical scientific staff.

A. W. Barrett
East Grinstead

1. ISI Web of Knowledge website. http:/jcr02.isiknowledge.com/JCR/JCR

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Academics: Why has everyone left?

Sir, we write in response to Professors' Kay and O'Brien's opinion piece: *Academics: Where is everyone?*[1] While we fully agree that academic dentistry is an extremely rewarding profession and we obtain great job satisfaction from our roles, we have concerns that the picture is not quite as glowing as painted.

A manpower survey by the University Teachers Group of the British Orthodontic Society in 2005 found that in the UK there are now only 33.95 WTE academics in orthodontics. In addition to the training of all undergraduates, they are responsible for the supervision of 148 postgraduates and 29 MPhil/PhD students. This is likely to be compounded by the increased numbers of undergraduates being recruited to dentistry. Of even greater concern is the low number of lecturers in training. In orthodontics there are currently four lecturers in training in the UK, one of whom is on a short-term contract, compared with 12 in 1994, a drop of almost 70%. If this shortage is not addressed now, the profession will face significant problems in the future. It seems unlikely that orthodontics is alone amongst the dental specialties to have such low numbers when a 6% drop in clinical academics overall in dentistry has been reported in a single year, 2003/4.[2]

All of this ultimately impacts on patients. In addition to teaching and research, many academics are involved in university and college examinations, college committees, national and international committees, also significant University and NHS management roles. It is important for academics to have these various commitments in order to influence future development of the dental specialties. While the recent advertisements for new academic posts are to be welcomed, these alone cannot make a significant impact on recruitment. They result from the recommendations of the report commissioned by the UK Clinical Research Collaboration (UKCRC) and Modernising Medical Careers, chaired by Dr Mark Walport. Sadly, the funds being made available are insufficient to cover medicine, let alone dentistry, and will not replenish the many lost posts.

Most clinical academics would agree that, not only has the amount of work increased in recent years, but the type and complexity of the work expected of them has also changed. Some academics have left academia for NHS or private practice posts due to poor promotional prospects and exceptionally long hours. The many demands on their time have undermined the opportunity for good quality research or for the other elements of the job which attracted them to that career in the first place. Non-clinical academics are able to spend more time on research, which improves their prospects for promotion within the university structure; account needs to be taken of this inequality. The future of any profession is undermined when people leave, significantly weakening the prospect of better, evidence-based treatments, teaching methods etc.

We need to find more ways of encouraging graduates into academia but also find ways of retaining them. So what could be done? A different career progression is required which is designed specifically for clinical academics, with reduced pressures for a defined period whilst training progresses. The prospect for promotion needs improvement with better mentoring. This clearly needs the universities to understand and agree to the changes. A slow but steady increase in manpower is required to share the load.

Perhaps now is the time that dental bodies and Government officials communicate directly with the clinical academics at the coalface, in order to achieve tangible results before it is too late. With high-level intervention, it may be possible to engage the Universities in making the necessary changes.

The British Orthodontic Society would wish to support any measures which can encourage better recruitment and retention of high calibre academic staff in dentistry.

I. Hathorn
Chairman of British Orthodontic Society
F. Luther
Chairman of the University Teachers Group of the BOS
S. Cunningham
Secretary of the University Teachers Group of BOS
By email

1. Kay E J, O'Brien K D O. Academics: Where is everyone? *Br Dent J* 2006; **200:** 73-74
2. Hobson R. Dentistry's Catch 22. *BDA News* 2005; 18.

doi: 10.1038/sj.bdj.4813539

The wrong journal

Sir, I read the opinion paper by Pamela Ward *The changing skill mix – experiences on the introduction of the*

dental therapist into general dental practice (*BDJ* 2006; **200**: 193-197) with interest. Nevertheless, as the editor of the journal concerned, I would like to point out an error. The paper contains a sentence which begins 'However, both the BDA (*Vital*) and the FGDP (*Primary Care*) have begun to produce journals for the whole dental team...'

The journal concerned is *Team in Practice* and not *Primary Care*. *Primary Dental Care* is the journal of the FGDP. I would be most grateful if you could publish this correction as soon as possible.

K. A. Eaton
London
doi: 10.1038/sj.bdj.4813540

Where has all the caries gone?

Sir, after the last Children's Dental Health in the United Kingdom Survey we have been somewhat self congratulatory (especially the Government – who may even have been a little smug) on the fact that 12-year-olds in the UK had the best dental health in Europe. Sometimes this is a little difficult to equate with what some of us witness on a regular basis. Colleagues may be interested to know the results of a school dental screening of an infant school in the suburbs of Leicester last month. This is in a moderately deprived area and has primarily Caucasian children in attendance. Of the 119 children examined: 45.4% required referral for further investigation; 12.6% had one or more abscesses; 22.7% had three or more teeth decayed; with the highest number of teeth affected with active decay in one child being 13.

Although it is accepted that there are outliers in all walks of life, it is plainly unacceptable that by the year 2006 children attending a primary school in England should harbour such poor dental health. On an epidemiological basis, little has changed locally dental health wise for this age group over the last 15 years, but services have. The Community Dental Service was instructed by government to direct all routine patients to GDS colleagues, and is now a referral service primarily for those same colleagues. With the new contract imminent and some local colleagues in the GDS informed by the PCT that they already have too many patients, and need to shed some, where should the children requiring referral seek dental care? Perhaps we should not be asking where has all the caries gone, but where have all the services gone and just who is going to provide treatment for children in need with high rates of dental decay? Access, I see no access.

C. Dugmore
By email
doi: 10.1038/sj.bdj.4813543

3D airway changes

Sir, I note with some interest the recent debate on the aetiology and management of malocclusions, following the letters from Drs Horobin and Broadway. As I am actively involved in orthodontic research, I understand that malocclusions are commonly encountered in modern civilisations most likely due to changes in environmental conditions, such as feeding behaviour. Malocclusions might begin at birth, as modern mothers are less likely to breastfeed a child, whereas primitive man did so exclusively. Similarly, while the young children of primitive man did not ever use pacifiers or bottle-feed their children, these recent changes in environment/behaviour might be associated with malocclusions such as anterior open bite, which was so rare even a century ago that Edward Hartley Angle omitted this malocclusion from his classification system.

In terms of cause and effect, it is likely that upper airway obstruction is associated with malocclusion, and I am currently investigating 3-D airway changes (using a non-ionising, non-invasive protocol) to establish this association. Nevertheless, there is no doubt that there is a certain genetic susceptibility to developing a malocclusion, as genes that encode for skeletal, muscular and dental tissues have been identified and sequenced. Due to temporo-spatial patterning and gene-environmental interactions, an altered maxilla has concomitant effects on the developing mandible, and these effects can sometimes be clearly seen in children who manifest malocclusion as part of a craniofacial syndrome. In order to explain these associated phenomena I developed the Spatial Matrix hypothesis[1] using the Functional Matrix hypothesis as a starting point, which according to Moss[2] was first formulated by van der Klaauw.[3]

G. D. Singh
Puerto Rico

1. Singh G D. On growth and treatment: the Spatial Matrix hypothesis. *In* McNamara J A Jr (Ed). *Growth and treatment. Craniofacial Growth Series.* pp 197-239. Ann Arbor, USA: Monograph 41, 2004.
2. Moss M L, Young RW. A functional approach to craniology. *Amer J Phys Anthropol* 1960; **18:** 281-292.
3. van der Klaauw C J. Cerebral skull and facial skull. *Arch Neerl Zool* 1946; **7:** 16-37.

doi: 10.1038/sj.bdj.4813542