# Letters to the Editor

Send your letters to the Editor,
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Priority will be given to letters less than 500 words long.
Authors must sign the letter, which may be edited for reasons of space.



## DIMINISHED, SIDELINED

Sir, K. Marshall (*BDJ* 2009; **207:** 53) takes issue with the position struck by the GDC in its publications. K. Marshall's letter, taken together with the article you publish by Dr Shaw (*BDJ* 2009; **207:** 59-62), focuses exactly on the issues that determine the image the public have of the dental profession.

The layperson, indeed the long qualified dental surgeon, might be hard pressed to make the distinction between the professional and ethical practice that Dr Shaw defines.

However, that distinction is of real significance. The profession wished to advertise and to market its services. It wanted to be allowed to make the public more aware of what could be achieved, not only for the benefit of greater oral health but also for elective cosmetic improvement. It is as difficult to make a distinction between that informing role and 'soft selling' as it is to make a distinction between professional and ethical practice. If, in making full explanations of advances in our skills and techniques, we place goods in our shop window, there is a potential conflict of interests. It is our professional duty to explain alternative treatment strategies. However, advice may be couched in terms which favour the better commercial interest of the dentist; lip service may be paid to informed consent and all professional obligations discharged, but the treatment provided would only be ethical if it were also in the best interests of the patient in so far as the dentist can assess them.

There can be little doubt that the movement from dental practice entirely directed at the prevention and treatment of disease towards practice actively marketing elective procedures has contributed, as a spin-off benefit, much to a greater awareness of oral health issues. However, it has also contributed to qualification of the level of trust we enjoy as dental health care professionals. The profession has created different demands and must now supply.

The layperson has become a sophisticated consumer. Patients become aware that they are now regarded as customers as much as patients. They apply the same objective approach of 'caveat emptor' in approaching a dentist as they would in approaching a car salesman and perhaps for similar expenditure. They recognise the potential conflict of interests. It is difficult for us as a profession to see that change as anything less than a loss of trust, but in effect, the profession has been prepared to sacrifice the basis for that trust. We have raised our game, we achieve beautiful results, but our 'customers' recognise the difference between the provision of basic health care and the selling of additional services. They perceive commercial advantage. That is a change we have actively brought about.

The GDC has been taken over by laypersons and the role of the dentally qualified practitioners and academics within the GDC has, to a great extent, been diminished and their opinions sidelined in its considerations. The general public's altered attitudes of qualified trust are now reflected in, and seem to me to prevail in the approach to our regulation. The GDC is indeed specifically not there to support dentists, it is there to maintain professional standards. That may come to mean regulation not only of clinical competence, but also of ethical selling and of commercial standards of trading.

Be careful lest you get what you wish for!

**A. T. Hyatt**
**London**
**DOI: 10.1038/sj.bdj.2009.1016**

## GOLD ONLAYS

Sir, I read with great interest the article entitled *Long-term survivals of 'direct-wax' cast gold onlays: a retrospective study in a general dental practice* by L. K. Bandlish and G. Mariatos (*BDJ* 2009; **207:** 111-115). I certainly agree with the author's conclusion that the onlays made up of a direct wax pattern have a better clinical longevity compared to onlays made up of an indirect wax pattern. However, I have some queries regarding the presented manuscript. First, in Figure 1c, the photograph shows two proximal gold inlays on two separate molars. But the figure legend explains it to be onlays. How is this possible? According to Sturdevant,[1] an onlay is defined as an indirect restoration which involves the proximal surfaces of a posterior tooth and caps all of the cusps. But in the present case, all the cusps of the tooth are uncapped. Hence, I feel the case which is presented in the manuscript is an inlay and not an onlay. Second, in data collection, one of the failures of the restoration is defined as a restoration fracture and an unsuccessful endodontic outcome for a non vital tooth. I feel that an onlay cannot fracture. It can perforate due to thin margins or less bulk of the metal. Also, how can an onlay cause an unsuccessful endodontic outcome for a non vital tooth?

**V. Ballal**
**Manipal**

1. Roberson T, Heymann H O, Swift E J (ed). *Sturdevant's art and science of operative dentistry*, 4th ed. p 826. St Louis, Missouri: Mosby, 2001.