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.

LETTERS

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 con-

tributed, 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.

The authors respond: We thank you for your kind words and your appreciation of our study. First of all, however, let's clarify the fact that we never claimed that 'direct wax' onlays have better longevity than indirect ones. In fact that hypothesis was not tested. Our study demonstrated that 'direct wax' onlays have a comparable longevity to previously reported indirect restorations and that this method is viable under a general dental practice environment.

Now, considering your question about Figure 1c, indeed LL7 was an inlay and consequently not included in our study; LL8 on the other hand was an MO onlay: due to its partial nature, the distal cusps have been covered, but not the mesial ones (and this might possibly be the reason for their worse survival compared to the full MOD onlays).

As far as the fracture criterion is concerned, onlays do not really fracture, with exception maybe of a very thin isthmus; this option was included for the sake of completeness. Moreover, perforations have been included into this category.

Finally, concerning your interesting comment of non vital teeth endodontic outcome. Strictly speaking, any restorative procedure on a root treated tooth may cause microleakage and hence endodontic failure. Now, how likely this is to happen, there is no evidence. In our opinion reasons intrinsic to the endodontic procedures are more likely to cause failure, but the aforementioned case cannot be ruled out.

DOI: 10.1038/sj.bdj.2009.1017

DISINGENUOUS VIEWS

Sir, I read with some interest the reply to my letter *Another hiccup* (BDJ 2009; 206: 509) by I. Brook and C. Freeman. My letter drew attention to an anomaly of registration that has led to a perceived unfairness to dual qualified consultant oral and maxillofacial surgeons registered with the General Medical Council (GMC) and the General Dental Council (GDC). It was with some regret and disappointment that I note the statements contained within this letter.

Statements published by the GDC,¹ the British Association of Oral and Maxillofacial Surgeons² (BAOMS) and the Postgraduate Medical Education and

Training Board³ (PMETB) all define very clearly that the scope of work outlined by I. Brook and C. Freeman is well within that defined to be the remit of oral and maxillofacial surgery consultants.

I was also dismayed that the authors have sought to extend my personal views on an anomaly for temporary registered dentists to that of an advisory matter from BAOMS. The latter has in no way advised any of its fellows with regards to whether they should be registered with the GDC and have merely outlined the new GDC rules of registration.

Oral and maxillofacial surgery is now a medical specialty and I direct the authors I. Brook and C. Freeman to any of the references listed below, which are and have been readily available within the public domain. The scenario they present does not present any difficulties with regards to the defined remit of practice by a dually qualified, singly registered consultant oral and maxillofacial surgeon and the publication of such disingenuous views does not help what has been a difficult situation to address.

S. Laverick
By email

1. General Dental Council. Practice of dentistry statement. www.gdc-uk.org/NR/rdonlyres/563578AC-10D2-4A8B-A3FF-6B029F5E772E/76102/Practiceofdentistrystatement.doc (accessed 2 November 2009).
2. British Association of Oral and Maxillofacial Surgeons. BAOMS position statement: The practice of oral and maxillofacial surgery (OMFS) by non-GDC medical registrants. <http://www.baoms.org.uk/downloaddoc.asp?id=212> (accessed 2 November 2009).
3. Intercollegiate Surgical Curriculum Programme. Oral and maxillofacial surgery syllabus webpages. <https://www.iscp.ac.uk/Syllabus/Overview.aspx?enc=1kC9R8VOUhgYwUJWLF7uSFGHkUwSFKlosHepYhBHhX0=> (accessed 2 November 2009).

DOI: 10.1038/sj.bdj.2009.1018

UNDERPINNED BY EXPERIENCE

Sir, I write regarding the news story titled *New professor appointed* (BDJ 2009; 207: 150). As Head of the School of Dentistry at the University of Central Lancashire I wish to inform colleagues that I was not involved in this appointment as it is in the Institute of Postgraduate Dental Education that is not part of the new graduate entry dental school. My personal view on academic appointments has not changed since I published the article *Science, myths and lies in*

dentistry (BDJ 1991; 171: 74). In those days I was an angry young man, now I am a grumpy old man; but I still believe that the award of academic titles should be underpinned by traditional academic training and experience.

L. Mair
Preston

DOI: 10.1038/sj.bdj.2009.1019

USE OF HOISTS

Sir, I am writing to you in response to the article *Obesity and dentistry: a growing problem* (BDJ 2009; 207: 171-175). I would like to add a few points.

It would be pertinent to mention about the use of hoists. When I attended the induction programme for my first job as a community dentist, I was introduced to the use of hoists for lifting bariatric patients. These hoists are available in different makes and sizes and each has a recommended maximum load it can lift. In surgery I have used the hoist a few times to transfer patients from wheelchair to dental chair.

We also have a very wide wheelchair designed for bariatric patients and we use a wheelchair tipper which again is indispensable for such patients.

These patients are also a high risk category for treatment under general anaesthesia. One of my bariatric patients went into cardiac arrest on the operation table when she had to undergo full clearance under GA. She had to undergo a defibrillator to start her heart again and the operation had to be abandoned.

Z. Imran
Dundee

DOI: 10.1038/sj.bdj.2009.1020

ODD PRACTICE

Sir, in the online edition of the *BDJ*, Khosropanah *et al.* report (BDJ 2009; 207: E8) the results of an unusually designed study which assessed the efficacy of panoramic radiographs to detect carotid artery calcifications by determining the level of agreement between the radiographs and Doppler sonography (DS).¹ The study design is odd and a reverse of usual clinical dental practice in that they referred for radiographs patients who had already had a physician obtained DS study. The authors determined that the level of agreement between the two imaging sys-