interesting study. For more information on IOM please visit the Dentaaid web-site <http://www.dentaaid.org/resources/iommaterials>.

J. Gollings
Poole

DOI: 10.1038/sj.bdj.2011.433

REMAINS OF THE DAY

Sir, of course, as always and quite rightly, you seek to provoke us (*For want of a nail*; *BDJ* 2011; 210: 245) and I wish to accept this particular challenge.

The key points you make are, incontrovertibly, that there is a massive decline in caries and therefore a concomitant increase in the number of people having functional natural dentitions in the UK. The second 'conflicting' trend you introduce is that there is a corresponding increase in the number of dentists and also dental hygienists and therapists in the UK, arguing that these dental professionals will become increasingly 'under-employed and at worst unemployed'.

My opposing argument is that this is false reasoning because you did not take into account the fact that the people with functional natural dentitions are living longer. They also wish to keep their functional natural dentition because they are better educated and they have greater disposable incomes to spend on dentistry. They perceive that keeping the natural dentition maintains the quality of life. Because of the increasing importance of the media and visual communications they also perceive that this quality of life may be improved by changing the aesthetics of these ageing teeth with whitening, cosmetic treatment and adult orthodontics. In addition, with the increasing availability of implants the loss of a functional tooth is now no longer regarded as irreversible, at any age.

To carry out these complex procedures, periodontal status has to be improved and maintained. The Adult Dental Health Survey 2009 reports: '*Periodontal disease remains common at a low level although overall there has been a reduction in mild disease associated, perhaps, with a general increase in cleanliness. However, there has been a slight increase in the prevalence of more severe disease and the impacts of severe*

disease are concentrated in a relatively small proportion of the population'. I would suspect that as more teeth are kept for longer, with the reduction of caries and increased longevity, the incidence of periodontal disease in older people will actually increase. Not only that, but as the recommendations for early diagnosis and treatment become more stringent, the need for periodontal treatment will further increase.

Neither did you report on the 'new' disease of tooth surface loss which has replaced caries in younger patients as the biggest time consuming challenge for many practitioners. We also need to consider preventive strategies in older patients for the treatment of dry mouths and root caries. In addition, the clinical output of each individual dental professional will probably be reduced in future by the time consuming needs of clinical governance, the Care Quality Commission and reaccréditation.

Finally, the main increase in numbers of dentists in the UK is probably nothing to do with the UK government's increase in training places, but is more to do with market forces and the influx of dentists from the European Union and is therefore beyond the control of planners. I conclude that demographic change, increased dental awareness and the need for preventive strategies will increase rather than reduce the demand for treatment in primary dental care.

M. Austin
Hove

DOI: 10.1038/sj.bdj.2011.434

REFRESHINGLY REALISTIC

Sir, I note from the letter of J. Truter (*Shame on the MPs*; *BDJ* 2011; 210: 97) that the response of their MP was a standard letter. This may well be a result of the use of a standard postcard.

My experience with my MP was very different as she entered into a personalised exchange of emails. She was keen to learn more of my opinions and was, at all times, refreshingly realistic as to what could be achieved. At one stage my concerns, along with those of other constituents, were raised with Lord Howe the health minister who provided the assurance that CQC regulation is intended to be 'light touch'.

It is too easy to generalise in these circumstances; there are open minds in government.

M. P. Davies
By email

DOI: 10.1038/sj.bdj.2011.435

SPLINTS AS PLACEBOS

Sir, I refer to the letter from J. M. Zakrzewska on behalf of the facial pain unit Eastman Dental Hospital.¹

A multi-disciplinary approach is essential in understanding and treating 'TMD'.

Splints or bite raising appliances cannot be considered as 'placebos' as they, by definition, have a definite physiological effect. They should therefore be considered as 'pacifiers or comforters'.

In my experience, inserting a longitudinal cut length of a cotton wool roll of equal thickness on the lower posterior teeth of each side of the dental arch and guiding cushioned closure will reduce the tension in the oral, mandibular and swallowing musculature, by removing the displacing premature occluding contacts.

This simple procedure in itself is very informative for the patient and dentist.

C. G. W. Wilks
Billesdon

1. Zakrzewska J M. Consistently amazed. *Br Dent J* 2011; 2011: 248

DOI: 10.1038/sj.bdj.2011.436

REFRESHING DISCUSSION

Sir, I congratulate Brocklehurst and Tickle (*BDJ* 2011; 210: 303-308) for focusing on the business aspect of delivering dental care in the primary care setting, by using skill mix.

We are all aware of our duty to patients and improving oral health outcomes. However, primary dental care is foremost a 'business' and with a significant risk borne by many of the practitioners reading this journal. It is refreshing to see an open discussion and exploration of the profitability in using dental therapists, dental hygienists and/or extended duty dental nurses. Naturally, a simplified business model has been used in the paper and every practice will need to look at their own individual circumstances when considering skill mix. Over the last few years, there has been a particular drive by PCTs in implementing