profession shortly is proof of the failure of our professional regulators to act in our best interests and prepare us for the future and so is the CQC furore.

The ramifications are significant and create yet another damaging blow to the low morale of the dental team. Keith is right – on the present evidence, the GDC is cash-greedy, outdated and patronising.

N. J. Knott
By email
DOI: 10.1038/sj.bdj.2011.7

## DUTY OF CARE

Sir, I read with interest your recent editorial (*BDJ* 2010; **209:** 421) regarding ethics in today's dentistry. It was followed by a letter from A. Sorrell (*BDJ* 2010; **209:** 423) raising a number of points on corporate bodies and their apparent failings to provide a duty of care to some patients. There has been frequent discussion concerning dentists who may be under pressure regarding UDAs having to pick and choose the treatments received by patients in high need. One must remember our duty of care is to our patients, not our employers.

In addition to the points raised by A. Sorrell, I would like to draw attention to the misuse of the referral system which I have observed whilst working in the hospital environment. It sees high numbers of routine restorative treatments which may not be financially beneficial to the dentist finding their way on to hospital waiting lists. Whilst teaching hospitals are thankful for some routine treatments for undergraduate students to put into practice skills learnt on phantom heads, patients can spend months waiting for treatment, often in pain and end up needing treatment which is more extensive than when the referral was originally made.

Many referrals extended to oral surgery where patients were referred for routine extractions due to 'dental anxiety'. This anxiety was often not known to the patients concerned who were more than happy to have extractions under local anaesthesia. I am unsure whether the reason for these referrals is due to the UDA structure or the recognised lack of oral surgery experience as an undergraduate for recent graduates.

In a manner as to not discourage referrals, repeat referrals for routine treatment from the same dentists/practice may warrant further investigation. These dentists may appreciate support from postgraduate centres. Appropriate practical courses may improve the dentists' confidence in providing certain treatments for their patients.

Whilst the option remains for hospitals to write back to dentists enquiring as to why certain treatment cannot be carried out by the referring dentist, this places the patient at a further disadvantage of waiting even longer for treatment. Hence patients getting treated using hospital resources. One would hope the ongoing review and future proposals for the UDA system may improve this situation.

Finally, I would like to acknowledge that not all questionable referrals I have experienced were from corporate bodies, but a significant majority were from that source.

S. Roddis
By email
DOI: 10.1038/sj.bdj.2011.8

## FOUR HANDED WISDOM

Sir, I write in regard to the letter *Musculoskeletal pain* (*BDJ* 2010; **209:** 425). When I was a dental student in the late sixties, early seventies I remember having one session on 'four handed dentistry' with Ellis Paul who was a part-time lecturer at Liverpool Dental School.

The most important aspect I remember was obtaining the correct seating position and height of the operating stool for oneself before approaching the dental chair to set its height and tilt and then positioning the headrest.

For the 36 years I was in practice I rarely suffered from musculoskeletal problems, in fact if I came in to work on a Monday morning suffering from the effects of gardening over the weekend, by mid-morning the stiff back would have eased considerably. It is easy to maintain these positions with presets on the dental chair and of course, if nobody else uses one's surgery!

The few times that I did have trouble was usually after my clinical assistant session at a local hospital in a surgery which was used by many other dentists. By the end of the following week any adjustments I had made would have long been changed!

Whilst I did not take my four handed skills to the heights of Mr Paul's ability I am grateful for his words of wisdom all those years ago.

K. Maunder
Spondon
DOI: 10.1038/sj.bdj.2011.9

## UNDERMINING CONSENT

Sir, I am an orthodontist and have for many years practised a form of non-surgical therapy called orthotropics, the name of which may well be familiar to your readers. I have found this able to avoid orthognathic surgery for many patients who had previously been told that surgery was the only option. In my estimation these results were often as good as, if not better than 'conventional' surgery.

As a result of a recent General Dental Council hearing, in which I was involved, the Council has decided that it is not necessary for orthodontists, even when proposing major orthognathic surgery, to include the possibility of being treated by orthotropics. I believe that this undermines the basis of informed consent as it should be the patient who decides which treatment they prefer and they can only do that if they are aware of alternatives. I will be pleased to hear, through your columns, from colleagues as to whether they think this is a retrograde step.

J. Mew
By email
DOI: 10.1038/sj.bdj.2011.10

## APPROPRIATE DISPENSING

Sir, I have enjoyed the series of cover images in Volume 209 of the journal, where abstract art depicts one of the GDC specialties. The cover on Issue 6, however, representing paediatric dentistry, raises an issue which is often overlooked when depicting images of a toothbrush and toothpaste. The graphic shows two brushes, overloaded with copious amounts of paste, a not uncommon finding in illustrations and photographs used in health education material aimed at young children and their parents. Since the early 1990s[1] it has been agreed that the amount of toothpaste used by children should be restricted