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.

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LETTERS

FREE TO INNOVATE

Sir, earlier this year Lord Saatchi launched his Medical Innovation Bill with the aim of changing the current culture within the profession that makes practitioners fearful of the new and untested. Under the heading 'The fear of being sued is ruining modern medicine' Dr Max Pemberton, in *The Telegraph* (10 December 2012) wrote that 'Evidence-based research, whilst noble in theory, in reality is not always realistic given the complex nature of some medical problems'.

Within the dental profession a similar dilemma exists particularly in the field of chronic head and neck pain related to dental occlusion and TMJ problems. Where mainstream treatments, such as rest, reassurance, night guards, analgesics and counselling have failed, the practitioner wishing to best serve his patients may wish to try methods which are not supported by evidence-based research.

'Frightened of litigation many practitioners do not push the boundaries of medical knowledge and opt instead for the "safe" standard procedures. This attitude is not good for patients who are denied the chance of cutting edge techniques when they have little or nothing to lose. It is not good for practitioners who are constantly questioning what they do or don't do – not on behalf of the patient, but because they fear having to justify what they are doing in front of cross examination.'

Practitioners are bound by professional guidance and their duty of care to their patients still remains. Where the evidence is shaky or wanting or not clear, then practitioners should be free to innovate, and this is what Lord

Saatchi's Bill suggests. Let us hope for the sake of our long suffering chronic pain patients that more useful treatments will be accepted, rather than just 'learning to live with pain'.

R. Dean

By email

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SHORT-LIVED BENEFITS

Sir, Dr A. Maini's article on short-term cosmetic orthodontics (*BDJ* 2013; 214: 83) is appropriately named as the benefits of this approach to treatment in many cases are destined to be short lived. For the benefit of readers who may be seduced, orthodontists have learned the hard way that very few patients successfully sustain wearing removable retainers on a long-term basis. The great majority of adult patients need permanent retention, not just some night-time device for a year or two. The only reliable retainers for long-term use are palatal or lingual bonded wires which must be out of occlusion. In the upper arch, this means that overbite reduction is often necessary which usually means that treatment will take longer than six months and that full appliances will be required in both arches. One wonders how many quick fix patients are informed in a clear and unambiguous way that their few months of short-term orthodontics will be just that, short-term, unless followed by a lifetime of retention.

R. Kirschen

Reigate

Dr A. Maini responds: I completely agree life long retention is imperative with any adult orthodontics. All my patients have verbal and written

understanding of the importance of retainers. If need be we can fit upper retainer wires by either minor lower incisor intrusion or by deep bite correction with levelling of the curve of spee. This can be done within the scope of short-term orthodontics.

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PROVIDING A CHOICE

Sir, Mr Maini's article¹ states that 'short-term cosmetic orthodontics' is a treatment concept within the comfort zone of general dental practitioners. There are two issues that need to be considered: firstly, those related to consent, and secondly, the scope of specialist orthodontics.

Clinicians are ethically bound to have a full and open discussion with a patient regarding the relative merits and risks of all available options for treatment. Central to this report is the concept of 'providing a choice'. When there is only a limited choice available, however, this would seem contrary to our duty of care. Patients may not have occlusal problems as their primary complaint, but to dismiss comprehensive correction in favour of a cosmetic compromise, without full and impartial discussion, risks falling foul of the central tenet of informed consent. A comprehensive diagnosis is essential prior to providing fully informed consent. The taking of consent, before treatment begins, should be undertaken only by an individual who is aware of all the options available, together with the likely result if no treatment is undertaken, and the risks and benefits of all treatment options.

Short-term treatments have been and remain a valid treatment option within

specialist orthodontics but it would be misleading to suggest that difficulties do not arise. Seemingly straightforward treatment with a sectional fixed appliance can be complicated by quite pronounced changes in overbite and overjet or flaring of the canines, all of which can be difficult and time consuming to correct. Further, an inadequate retention protocol following active tooth movement might lead to significant relapse, resulting in costly remedial work for the patient, especially if additional restorative work has been performed.

The concerns raised in this letter are not unfounded; there is evidence to support a rising trend for medico-legal problems in orthodontics. In 2010, 20% of dento-legal claims arose from aligner type treatments with 80-90% of these against general dental practitioners (Dental Protection, *Riskwise UK 42*). Also, in the current issue of *Riskwise* (issue 44), Dental Protection strongly welcomes the underlying principle (stated in the Office of Fair Trading OFT report on the 'dentistry market') of allowing patients to make properly informed decisions, and to encourage them to seek information they need so that they can properly understand what treatment options are being proposed, and what they will be expected to pay. In the same issue, Dental Protection reiterated the importance of the GDC document entitled *Principles of ethical advertising*, which state: 'All information or publicity material regarding dental services should be legal, decent, honest and truthful'.

The author appears on the Six Month Smiles website as an 'Instructor'. This seems to suggest a commercial interest in the particular treatment system which is not apparent when reading the article. If so, in our opinion, this should have been made clear.

R. Slater
N. Hunt

British Orthodontic Society

1. Maini A. Short-term cosmetic orthodontics for general dental practitioners. *Br Dent J* 2013; 214: 83.

Dr A. Maini responds: Thank you for your letter. The aim of the article was written in a cosmetic dentistry perspective as

an aim for dentists to use orthodontics to improve anterior tooth alignment without having to prepare teeth with a restorative solution. You will agree the biomechanical impact of aggressive tooth preparation has far greater impact on the longevity of the teeth than just aligning some anterior teeth. The ethos is to provide far more minimally invasive solutions and as Vice President of the British Academy of Cosmetic Dentistry this is our centred opinion as we try to move the profession away from the 'veneer' smile makeover that typifies cosmetic dentistry. I do teach for a company called Six Month Smiles and that was declared in my bio; also the article was far broader as it discussed many other products including removables.

Every patient who seeks a smile enhancement treatment should be offered all options to achieve correct valid consent; that may include restorative, short term orthodontics or comprehensive orthodontics, any of which could be undertaken by the GDP or referred to a specialist as appropriate according to the GDP's skill set in line with GDC guidelines.

Comprehensive orthodontics remain the 'gold' standard for any orthodontic care in terms of obtaining idealised Class 1 relationships and full root torquing and is the ideal and desired treatment for all patients who may entertain orthodontics. However, from my personal experience, in a clinic which also provides comprehensive orthodontics, a significant number of adult patients decline this option as they would not consider wearing braces for 18 months to two years. These patients would opt for either a restorative solution or do nothing at all if an orthodontic solution of a shorter time frame was not offered as an alternative.

Patients who undergo short-term orthodontics should be made aware fully as a part of the consent process that this is a compromise treatment and there are limits to what it can achieve in comparison to comprehensive orthodontics. Short-term orthodontics or comprehensive orthodontics can be referred to a specialist orthodontist if it is not within the skill set of the general dentist.

In general dentistry, as many of my colleagues will agree, many patients do not always choose ideal dentistry for many modalities such as restorative, implants, periodontics and endodontics; this is a fact of life and general dentists are used to working within a parameter that fits within the wishes of the patient.

The demand for short-term orthodontics will rise as dentists move towards more minimally invasive cosmetic dentistry techniques which is why it is great to see progressive specialist orthodontists like Asif Chatoo, Ian Hutchison and Derek Mahoney offering general dentists courses on short-term orthodontic techniques based on purely achieving anterior tooth alignment so that general dentists may offer this purely cosmetic treatment option with good training and support.

The figures you quote for Riskwise (issue 44) need to be brought into context. It is inevitable that as a treatment increases in volume there will be a respective increase in claims. Since most aligner treatments are provided by GDPs, with orthodontists offering these treatments to a far lesser degree and therefore the population of GDPs far exceeding the number of orthodontists, the 80-90% GDP claim is not as graphic as it might first appear.

On the subject of retainers, the philosophy is 'retainers are for life' which is a part of the consent process for short-term orthodontics. A patient who chooses not to do this is a poor candidate for the treatment. Having treated hundreds of relapse cases of adults who had comprehensive idealised orthodontics as teenagers I fully appreciate the importance of this.

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LOBBY FOR BETTER ORAL CARE

Sir, I was very interested to read D. Howarth's letter discussing the problems of implants and dementia (*BDJ* 2013; 214: 47). I completely agree that older people are a dental time bomb and that oral hygiene in residential care homes is often suboptimal to say the least, but I cannot agree that this is likely to cause more problems for patients with dental implants than it