CHARACTER SHAPING

Sir, as an oral and maxillofacial surgery SHO, it was recently bought to my attention that we should be fighting as dentally-qualified SHOs to keep our positions available for the future. There has been re-structuring in Oxford and the London Deanery to remove dentists from the rota and on-call duties. For other hospitals this brings into question the educational value and validity of dentists working in an OMFS team.

Before working as an OMFS SHO, horror stories floating around the dental world would have led me to ask the same question. However, over the last eight months to mention only a few incidences, I have prevented a partially erupted upper permanent incisor from attempted removal by a doctor thinking it was a broken fragment of tooth, and prevented a deciduous incisor from being re-implanted by a registrar unsure of eruption dates – not to mention our ability to diagnose or rule out dental abscesses. From an educational aspect, as a newly qualified dentist I considered myself under the heading of having had little undergraduate experience of minor oral surgery techniques. I now have a greater confidence and skill in surgical extractions and dealing with dental emergencies.

I realise our role on the ward is limited and a recent patient with tachycardia left me phoning my second-on-call. However, in a well-structured OMFS unit with MOS sessions and an A&E that realises they are referring to a dentally-qualified SHO, the experience gained is invaluable and character shaping to young dentists.

J. Armstrong
By email
DOI: 10.1038/sj.bdj.2013.634

AN OLD DRUM

Sir, with regard to John and Mike Mew's recent letters,[1,2] and Stephen Rudge's reply,[3] I would like to congratulate the *BDJ* for not publishing John's article. John has been beating a very old drum and we should not have to listen to his tune and have him insult our intelligence.

Treating 12 mm overjets on a non-extraction basis with functional appliances is bread and butter to me and most orthodontists. I do this under the NHS regulations and fee structures. I wrote a series of letters in the late 1980s in *Dental Update* regarding this. John has managed to build up a clique of followers and even set up his own 'school'.

To add to the list presented by Stephen, when I was in the hospital services, Bob Lee and the late David DiBiase offered John the facilities and expertise of the London and Southend Hospitals to prove his theories scientifically. John declined a number of times. We live in an age of evidence-based dentistry and we can't follow his mantra of 'do it my way or you will wreck faces'.

John, you are an intelligent man. After all these years you have to stop dragging out the odd case and put your theory to the test the proper way – or not at all.

R. Abrahams
Rickmansworth

1. Mew J. Jaw surgery alternatives. *Br Dent J* 2013; **214:** 376.
2. Mew M. Risking our legitimacy. *Br Dent J* 2013; **214:** 143.
3. Rudge S. Engaging fully. *Br Dent J* 2013; **214:** 430.

DOI: 10.1038/sj.bdj.2013.635

BONDING AGENTS

Sir, I must commend Dr Worskett for undertaking his research into bonded amalgams within a general dental practice setting (*BDJ* 2013; **214:** E19). However, the title should surely have been something more like *A comparison between NHS lathe cut amalgam and private high Cu spherical amalgam.*

By using two completely different amalgams there is no relevance to whether or not bonding agents were used. Surely the editorial board should have pointed this out and asked for revision of the paper?

A. Neill, Aberdeen

Dr Paul Worskett responds: I must thank Dr Neill for his comments but the comparison was not intended to be between NHS and private amalgams. The study was between non-bonded amalgams, which happened to be carried out under NHS regulations, and bonded amalgams. Dr Neill appears to make the incorrect assumption that the amalgam used for NHS amalgams was a low copper lathe cut alloy. The precise alloy used for non-bonded amalgams was not known but it is very likely it would have been Gs-80 as this has been used in the practice for many years going back to the late nineties and is still used today. Gs-80 is a high copper, non-gamma2, admix alloy marketed by SDI. However, I was not certain enough to be able to quote this alloy in the paper. If the amalgam used was not Gs-80 it would have been of similar quality.

The theoretical advantages of bonded amalgams have been verified in many in vitro *studies and these were reviewed in the article. Of course, it is very difficult to eliminate all the variables in a study, especially retrospective studies carried out in general practice. I had tried to discuss many of the variables of the study in the article. Also, in the discussion part of the paper, a comparison was made of the results of this study compared with other amalgam studies, including those carried out in academic settings which found an average failure rate of 3.3% for non-bonded amalgam restorations across all types of alloys.[1] In my study, the failure rate of bonded amalgams was between 1.5% and 2.5% per year over five years.*

Although there were acknowledged limitations of the study, the conclusion was that amalgams placed by the bonding and non-bonding techniques, using the methods described, yielded significantly different results. It is for the reader to decide the relevance of the findings in the light of the methodology used and the limitations of the study.

1. Hickel R, Manhart J. Longevity of restorations in posterior teeth and reasons for failure. *J Adhes Dent* 2001; **3:** 45–64.

DOI: 10.1038/sj.bdj.2013.636

YORICK CROWN

Sir, for me, the attraction to dentistry was its variety, manual dexterity requirement, constant mental (and physical) challenges, need for lateral thinking and flexibility. However, until recently, I would not have included unpredictable and unexpected surprises. The other day I had a visit from one of the most unusual patients I have