LETTERS TO THE EDITOR

Send your letters to the Editor, British Dental Journal, 64 Wimpole Street, London, W1G 8YS
Email bdj@bda.org. Priority will be given to letters less than 500 words long. Authors must sign the letter, which may be edited for reasons of space. Readers may now comment on letters via the *BDJ* website (www.bdj.co.uk). A 'Readers' Comments' section appears at the end of the full text of each letter online.

ORAL SURGERY

Comprehensive records

Sir, we refer to the letter *Oral surgery: Mandibular fracture risk* (*BDJ* 2016; **220:** 44) with respect to consenting patients for the inherent risks of procedures, in this instance the removal of mandibular third molars.

We do not disagree with the conclusion that it may be sensible to advise patients of the rare risk of mandibular fracture in the removal of lower third molar teeth. However, we would disagree that the warning should be given to all patients on the basis that it happened to one, particularly in circumstances where the likelihood of this happening was suggested to be as low as 0.005%.

It is worth spending a little time reflecting upon the judgement of Montgomery. Paragraph 89 expressly provides that the assessment of whether a risk is 'material' cannot just be reduced to percentages, but should be considered along with the nature of the risk, the effect which its occurrence would have upon the life of the patient, the importance to the patient of the benefits sought to be achieved by the treatment, the alternatives available, and the risks involved in those alternatives. The assessment is fact-sensitive, and dependent also on the characteristics of the patient.

From the letter of 22 January 2016, we do not know the idiosyncrasies of this patient, both in terms of his character and of his medical history. It may be that he was particularly susceptible to this kind of injury, which should have been appropriately assessed at the time of the initial consultation. If it was identified that he was particularly susceptible to fracture, this would have become a material risk and there would have been a duty to ensure he was aware of that risk. If there was no such susceptibility, then it was a fluke accident of a kind that the law courts in this jurisdiction will not punish.

The courts have expressly recognised that informed consent cannot include detailing every single eventuality that may arise from a procedure. This is why it has been limited to 'material risks'. We would suggest that side effects with a probability of 0.005% likelihood do not need to be included as a matter of course, but only where the circumstances make the risk material. Otherwise, practitioners will find their consent process takes an inordinate length of time, to the exclusion of all other clinical duties.

From a medico-legal perspective, the consideration of risk and consent process should be appropriately detailed in the medical records. It goes without saying that comprehensive records should be a fundamental part of the modern practitioner's clinical practice.

S. Stagnell StR Oral Surgery, B. Gil, Pupil, Old Square Chambers, London

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PHARMACOLOGY

Clarity on prescribing

Sir, in their seminal paper in the *BDJ* the authors are to be congratulated on providing GDPs with some clarity on probably the most important issue in dental prescribing.[1] Prior to 2008 antibiotic prophylaxis in cases of certain cardiac diseases was considered the sheet anchor of dental therapeutics; suddenly, overnight, what had been repeatedly instilled was dismissed as wrong and a thinly veiled inference put abroad that if the GDP prescribed, as it was his or her signature on the script, and not the cardiologist who had advocated it, then in the event of any untoward reaction the buck stopped with the GDP. Medical colleagues continued to be adamant that prophylaxis was necessary.

It was not made clear that the guidelines were advisory and most colleagues saw them as prescriptive. This made for some awkward conversations with medical colleagues who, as patients, had been advised by their doctor to take prophylaxis before certain dental procedures. Most patients who had previously been prescribed prophylactic antibiotics requested that it was continued. One must question how many patients have suffered unnecessary and chronically debilitating disease and even death because of a guideline in which the main driver seems to have been a small financial saving.

D. McIntosh, London

1. Thornhill M H, Dayer M, Lockhart P B *et al.* Guidelines on prophylaxis to prevent infective endocarditis. *Br Dent J* 2016; **220:** 51–56.

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ADVERTISING

TV dentists

Sir, my TV viewing is limited. Tonight an ad particularly irritated me, bringing my previously subliminal thoughts about TV dental product advertising to the surface.

If companies wish to advertise their products – fine. If the format of the advertisement is such that a dental professional appears to be fronting it, I am far from sure that it reflects well on the profession. Evidence basis and financial bias are among the many issues involved. I have not noticed similar TV ads involving our medical colleagues.

J. K. A. Parker, Hereford

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ORAL HEALTH

Praying for preventive care

Sir, in India, caries is predicted to increase significantly and oral cancer is a growing problem.[1] Meanwhile, the oral health workforce is showing a dramatic rise: the number of dental schools has increased from 95 to 290 within the last 20 years and more than 25,000 dentists are graduating each year in India.[2] Most schools are in urban regions and partly as consequence the dentist-population ratio is as high as 1:4,000 in urban India while in rural areas can be as low as 1:30,000.[2] Challenges include the fact that the disease burden is highest amongst the disadvantaged; oral health is not considered integral to general health; the inaccessibility of oral health services to people in rural regions; and much of modern dental practice is highly interventionist.

Whilst the small business model of dental

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