COMMENT

Letters to the editor

Send your letters to the Editor, *British Dental Journal,* 64 Wimpole Street, London, W1G 8YS. Email bdj@bda.org.
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Regulation

Is change impossible?

Sir, I enjoyed reading the article on *Self-regulation in dentistry and the social contract* (*BDJ* 2016; **221:** 449–451). For once, an article clearly emphasising the shift in dynamics of the GDC body from when it was first established in 1956. It is interesting to note that this opinion is shared by most, if not all dental professionals. Why is it then, that we as sound beings (and I am as guilty myself as anyone else) are sitting back and allowing the self-regulatory body to overpower us to the extent that we are frightened of practising our own profession? Are we waiting for someone to give us a voice? Little faith was pronounced to the BDA while they contested against the abominable rise in the Annual Retention Fee (ARF). Why are we afraid of taking matters into our own hands? As the deadline for the ARF once again arises in December 2016, what would happen if ALL of us stood united and decided not to pay this ARF? Surely not all dental professionals would be suspended from the GDC? We have forgotten that revolutions come about due to unity within communities... when people come out and SPEAK! It is sad that an individualistic society is now encouraged and unity and trust has depleted, not just between patients and dental professionals, but the whole of humanity in general. In a world where the masses sleep, the GDC can easily take the authoritarian stance because they know that although the majority of us will indeed be demoralised and upset, none of us will take a stand or refuse to pay their so called necessary fees. In the end our innate scepticism and obedience always makes us comply. When did we start believing that change is impossible?

A. Chaudhary, London

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Pharmaceuticals

Antibiotics and vegetarians

Sir, as professionals, we take great care in establishing if patients have any previous drug allergies or sensitivities; however, less commonly reported is what comprises the capsules, and the constituent elements of these medications. Though this information can be found in patient information leaflets, it is not common for patients to be actively aware of this, or to be given a choice over the matter. For certain patients, to treat them without clarifying this threatens the notion of valid consent.

We recently received a complaint from a patient, a practising vegetarian patient, who was unhappy that we were unable to guarantee his antibiotic prescription would be free from animal products. The antibiotics themselves are usually either derived from fungus, soil bacteria or are laboratory-synthesised, so generally are suitable for vegetarians and vegans. However, there is a general problem with capsules, as the majority of them are made from gelatine, an animal product.[1] Lactose is also used as a filler in tablets and capsules, and whilst this is acceptable to the majority of vegetarians, it is unacceptable to vegans; consideration to those who are intolerant to lactose should also be given regarding this point.

Often, tablets contain magnesium stearate as a lubricant during the tablet processing, and this is also derived from animal sources. Liquids can eliminate most of these problems, but again, the exact ingredients must be confirmed, as some colourings can come from crushed insects, for example cochineal.

Where other prescriptions are concerned in mouth care, for example in xerostomia management, a variety of non-animal derived, vegetarian-friendly alternatives exist; for example, AS Saliva Orthana contains porcine-derived mucin – however, vegetarian-friendly Xerotin may be used instead.[2] If, therefore, our patients feel strongly enough to opt for this, even when there is no ingestion of the medication, then is it not our duty to inform them that certain antibiotic prescriptions (which are swallowed and absorbed), may not be aligned with their values?

In some vegetarian patients who feel strongly about the consumption of animal-based products, regardless of the therapeutic value of medications, to omit information which they would attach significance to – the animal-based ingredients of their antimicrobials – could be seen as breaching Montgomery consent.[3] As practitioners, it is our responsibility to take a holistic approach to care with our patients, which encompasses their beliefs and wishes.

D. J. Smith, R. A. Ratansi, E. Mann, J. Russell, A. Kanatas, by email

1. Beddis H P. Pharmaceuticals: Animal ingredients. *Br Dent J* 2016; **220:** 557.
2. Jawad H, Hodson N A, Nixon P J. A review of dental treatment of head and neck cancer patients, before, during and after radiotherapy: part 2. *Br Dent J* 2015; **218:** 69–74.
3. D'Cruz L, Kaney H. Consent – a new era begins. *Br Dent J* 2015; **219:** 57–59.

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NOAC drugs

Sir, new oral anti-coagulant (NOAC) drugs have become increasingly popular. Recently, we have seen a series of three patients who were taking NOAC drugs, had extractions under local anaesthesia and returned to casualty due to extensive bleeding.

NOAC agents are often preferred to warfarin as they are easier to manage from a patient perspective. However, how easy are they to manage from the clinician's perspective?

These patients were either taking rivaroxaban or apixaban. Two patients were managed effectively with local haemostatic agents. One patient required admission for three days and received a two-unit blood transfusion.

In emergency situations, it is challenging to reverse the effect of these drugs as they cannot be reliably monitored. Comparatively, warfarin can be monitored via an international normalised ratio (INR) and reversed with vitamin K.

We recommend liaison with the clinician managing the patient's anticoagulation and discussion about stopping the NOAC drug 48 hours prior to the procedure, as suggested in the National Health Service (NHS) guidelines. We also encourage referral of these patients to a hospital setting, as necessary.

We are keen to hear from other clinicians with their experiences.

S. Mehta, Oxford

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OMFS

Times are changing

Sir, I'm writing in response to the letter from A. Ahmed on gender in OMFS (*BDJ* 2016; **221:** 372). Women in surgery is a topic close to my heart, not only because I am a female surgeon but it raises issues of motherhood and family life. You have raised very valid concerns. Questions that I have asked myself throughout my career.

I have recently returned to full-time registrar training in maxillofacial surgery and I can confidently say that women can definitely strike the balance between motherhood and pursuing a surgical career in a highly demanding and challenging field.

In my earlier years of training, I focused my energy in my career and accepted that getting married and having children would have to wait. I somehow resented being a woman as we had the 'biological clock' to contend with! Once I secured my maxillofacial registrar job, I knew I could finally settle in one location and everything started falling into place. I am now 34 years old and have a very supportive husband and a seven-month-old boy. I am back in full-time training and have worked a routine with my little boy so that I get to see him every day. At the same time, I am doing the oncology rotation within maxillofacial surgery, helping to organise an international conference, attending maxillofacial conferences and participating in research and audit – all of which are essential within our surgical training. Sometimes it seems like there are not enough hours in a day to get things done but as women, we have the unique ability to multitask and work efficiently.

Throughout my training, although most of the consultants are male, I have had the privilege of meeting inspirational female consultants. Two of whom are (were) also training programme directors of their deanery. They have families and perform brilliantly at their job. Role models like these are essential and they pave the way for female trainees to rise up to the challenge.

When it comes to employment and motherhood, we are entitled to 52 weeks maternity leave according to the Employment Act 1975. How about paternity leave? Two weeks was the standard up until 2013 (almost 40 years later!). I am a firm believer that fathers need to adopt the parent role as much as mothers do, and the image of mothers staying at home or taking time off training while their spouses climb up the ranks year after year is outdated. It is a culture we need to change and is changing! Fathers and mothers are now entitled to share the 52 weeks of leave. This change has made it possible for women to move up the ranks and continue pursuing their careers as much as their male counterparts.

You suggested that the gender imbalance in this specialty discourages women to pursue a career in maxillofacial surgery. This gender imbalance didn't deter me but instead pushed me to work harder. There is no reason women can't be in the same league as their male counterparts. Times are changing and so is the law. Now it is time to change the way we think!

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Women are catching up

Sir, I am glad A. Ahmed enjoyed her OMFS placement and I do hope she is encouraged to develop her career in the specialty.

I have been a Consultant Oral & Maxillofacial Surgeon since 1987. I was, of course, trained in the 'old days' before the double degree was mandatory. I am coming to the end of a wonderful career in the specialty but I was delighted when my unit recently appointed another female OMFS surgeon as a cancer surgeon.

Things are not as bad as your correspondent would suggest. There are a growing number of double degree female maxillofacial consultants and the number of trainees is encouraging. Careers in surgery have been an area where women were late to make inroads; however, women are catching up. More than half of entrants to medical and dental schools in the UK are now female and in 2014 29.5% of all surgical trainees were female. The Royal College of Surgeons in England supports women in surgery and a look at their website might help your correspondent address some of her concerns.

M. Morton, Consultant Oral & Maxillofacial Surgeon, Past president British Association of Oral & Maxillofacial Surgeons, by email

1. Ahmed A. OMFS: Gender imbalance? *Br Dent J* 2016; **221:** 372.

DOI: 10.1038/sj.bdj.2016.887

We are not alone

Sir, as a group of oral and maxillofacial surgeons it was heartening to hear of the benefit Ms Ahmed gained as a dental undergraduate from her two week placement in an oral and maxillofacial department. It is to her credit that she has recognised the holistic approach to patients presenting with the conditions she described.

We understand her raising the question about female representation at consultant level in the specialty, but as a group of female consultants we would like to state we are not alone! There is a gender imbalance in all of the surgical specialties and OMFS is not the worst, and the numbers of females in training is increasing all the time.

The female consultants in our specialty not only balance work and family life but are proportionately over represented in leadership roles such as on the Specialty Advisory Committee (SAC), as examiners for the Intercollegiate Examinations Board, and on the British Association of Oral and Maxillofacial Surgeons Council (BAOMS) and are actively promoting able female trainees into the specialty.

If Ms Ahmed would like to find out more about a career in our wonderful specialty she is welcome to track us down and find out more about it. In common with our male colleagues, we have worked hard, and also managed to lead relatively normal, if busy lives.

E. J. Woolley, Consultant OMFS Surgeon, North Wales; D. K. Dhariwal, Consultant OMFS Surgeon, Oxford; H. Witherow, Consultant OMFS Surgeon, London; C. Newlands, Consultant OMFS Surgeon, Guildford; K. George, Consultant OMFS Surgeon, London

1. Ahmed A. OMFS: Gender imbalance? *Br Dent J* 2016; **221:** 372.

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