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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Orthodontics

A number of points

Sir, in his most recent letter to the *BDJ*,[1] Mr Kilcoyne makes a number of points that require addressing. These centre around British advertising regulations and his opinion that informing colleagues about the problems of copying foreign corporate advertising claims is 'scaremongering'.

Firstly, Mr Kilcoyne states that the Advertising Standards Authority (ASA) 'only consider very clear orthodontic results from randomised clinical trials' when assessing such advertising claims of superiority. This statement is incorrect.

The ASA produce guidance on a range of different methodologies used to make claims of superiority in advertising. This guidance includes recommendations on the proper use of professional and patient opinions.[2-5]

The ASA also recommend that it is quite appropriate to make subjective claims through dentist/patient statements, but that any opinion expressing a claim that could be measured objectively should be supported with evidence.

This was the case in previous ASA rulings on the unsubstantiated and objective advertising claims made by certain adverts for Fastbraces and recent rulings on the advertising of Damon Braces.[6-7]

Claiming an orthodontic product produces faster, safer and less painful results without adequate evidence to back those claims up is misleading and could create unjustified expectations for potential patients.

If Mr Kilcoyne wants to advertise that he has treated 'a hundred consecutive good fast ortho cases as a clinician' he is more than at liberty to do this, as long the objective aspects of the claim can be justified.

Secondly, my main concern has always been that advertising within dentistry should not be misleading. I wished to highlight that claims made by foreign dental companies can be misleading. This is definitely a problem with some orthodontic products.

The main issue in the UK is that these foreign adverts rightly fall foul of British national advertising standards, but are outwith the ASA's jurisdiction. If these misleading foreign adverts are copied by British dental professionals, then they can result in that clinician failing to meet GDC standard 1.3.3:

'You must make sure that any advertising, promotional material or other information that you produce is accurate and not misleading'[8]

Indeed, the GDC produces specific guidance on advertising[9] which takes this further, stating:

'Whenever you, your practice, or any place where you work as a registrant, produce any information containing your name, you are responsible for checking that it is correct. You must:

- Ensure information is current and accurate;
- Use clear language that patients are likely to understand;
- Back up claims with facts;
- Avoid ambiguous statements; and
- Avoid statements or claims intended or likely to create an unjustified expectation about the results you can achieve.'

I do not think it is 'scaremongering' to make clinicians aware of ASA rulings on the misleading nature of claims copied from foreign orthodontic advertising.

To conclude, I would hope that those UK registrants who have relationships with overseas orthodontic manufacturers will use their contacts to lobby either for removal of misleading claims from their advertising, or investment in research which could help substantiate these claims.

This would be of benefit to our patients and for the reputation of the profession as a whole.

N. Stanford, by email

1. Kilcoyne T. Orthodontics: Unacceptable scaremongering. *Br Dent J* 2017; **222:** 744.
2. ASA - Substantiation - https://www.asa.org.uk/advice-online/substantiation.html (accessed 13 June 2017).
3. Advertising Standards Authority. Substantiation: Sampling References and Consumer Goods. Available at: https://www.asa.org.uk/advice-online/substantiation-sampling-references-and-consumer-goods.html (accessed 13 June 2017).
4. Advertising Standards Authority. Testimonials and Endorsements. Available at: https://www.asa.org.uk/advice-online/testimonials-and-endorsements.html (accessed 13 June 2017).
5. Advertising Standards Authority. Claims in Testimonials and Endorsements. Available at: https://www.asa.org.uk/advice-online/claims-in-testimonials-and-endorsements.html (accessed 13 June 2017).
6. Advertising Standards Authority. Search 'Fastbraces'. Available at: https://www.asa.org.uk/search.html?q=-Fastbraces (accessed 13 June 2017).
7. Advertising Standards Authority. Search 'Damon'. Available at: https://www.asa.org.uk/search.html?q=Damon (accessed 13 June 2017).
8. General Dental Council. *Standards for the dental team.* 30 September 2013. Available at: https://www.gdc-uk.org/professionals/standards/team (accessed 13 June 2017).
9. General Dental Council. Guidance on advertising. 30 September 2013. Available at: https://www.gdc-uk.org/api/files/Guidance%20on%20advertising%20(Sept%202013).pdf (accessed 13 June 2017).

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Primary dental care

Heresy, dam it!

Sir, the last heretic to be burnt at the stake in Britain was in 1612. Today punishments are more climate-change friendly, but still can result in erasure from the dental register. Still, I would like to dissent from established orthodoxy.

With regard to the article '*Dam it - it's easy!' - or is it?*,[1] it seems to suggest that there are no contra-indications or qualifications to its universal use. I beg to differ.

I have worked for many years treating phobics under IV sedation. I also worked for many years (outside the UK) as an anaesthetist. I remember being a lonely voice at SAAD meetings advocating a four-hour fast

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and now note that the profession is more in line with established anaesthetic practice.

Accepting that sedation is a continuum and doesn't divide strictly into classical Guedel planes, I would like to put forward the view that there are problems when using a rubber dam in combination with IV sedation.

Saliva pooling is hidden behind the dam and so cannot be visualised and suctioned directly. Second in the event of needing a rapid response to airway obstruction, precious time would be lost removing the paraphernalia of clamps. Even with endodontics, I think balancing risk against risk, it would be better to control against misplaced files with floss ties in preference to dam. Proponents of rubber dam should recognise that it is not a universal panacea and I hope that anaesthetists reading this will add their voice to my concerns.

R. Shamash, by email

1. Marshall K. 'Dam it - it's easy!' - or is it? *Br Dent J* 2017; **222:** 839–840.

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Dental history

Wartime dentists

Sir, I was interested to read in the *BDJ* of 9 June, Volume 222 No. 11, the article entitled *The first dentists sent to the Western Front during the First World War* (pp 893-897). My son Charles Sherwin (Guy's 1995) forwarded the *BDJ* to me as my grandfather, his great grandfather, Sidney William Bevis of Southsea, Hants (1890-1946) was a dentist in WW1.

He went to Guy's on 14 October 1909 and his registration date, LDS RCS was 21 June 1912.

In the *London Gazette* on 10 November 1914 he is listed as a Temporary 2nd Lieutenant in the RFA. His army record says he was a Dental Officer in the RFA.

On 18 August 1916, while still a Temp. 2nd Lt of the 107 Bde RFA he was awarded the Military Cross 'For conspicuous gallantry and devotion to duty in that when telephone and visual communication was impossible, and his orderlies were absent on duty, he thrice carried messages from the front line under intensely heavy shellfire', at La Briqueterie 18 August 1916, on the Somme.

He was promoted to Captain and then to Major. He sustained a severe leg injury and at the end of the war had to have his leg amputated. He practised after the war in South Norwood, SE London and subsequently Beulah Hill, Upper Norwood, until his death in 1946. This was no mean feat, standing on one leg and using a pedal drill with his artificial one. I have correspondence between him and various consultants at Guy's supporting his request for a War Pension following injuries sustained in WW1.

As I read the article it struck me that the six dentists mentioned in the article were all qualified in medicine and dentistry. Maybe there were many more dentists working in the field who, like my grandfather, were solely dentally qualified?

P. Sherwin, by email

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Occupational health

Accessing services

Sir, we read with interest the recent letter *Occupational health. An underestimation,* where the authors discussed the high levels of work-related mental ill-health (WRMIH) amongst dental practitioners and the important role that occupational physicians have in diagnosis and treatment of this condition.[1] We agree that timely management of WRMIH will improve well-being in dentists, allowing them to pursue a rewarding and happy career.

We would like to take this opportunity to highlight that all dentists in Northern Ireland and their directly employed staff, irrespective of where they work, are entitled to access Trust Occupational Health services. This access includes the facility of self-referral and we would encourage those in Northern Ireland who are experiencing WRMIH to consult their specialist Occupational Health service.

R. McMullan, B. Hendron, M. Donaldson, by email

1. Zhou A Y, Agius R, Carder M. Occupational health. An underestimation. *Br Dent J* 2017; **222**: 832.

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Risk management

An upstream approach

Sir, we read with interest the research article by Pearce *et al. (BDJ* 2017; **222:** 771–775) in relation to the remediation support provided for dentists in difficulties (DriD) from postgraduate dental teams (PgDT) and other sources.

At Dental Protection, we have accumulated considerable experience of helping dental members who discuss remediation with us in relation to concerns that have been raised about them, as well as supporting them when they have conditions imposed by the General Dental Council.

Being investigated by a dental regulator can be highly stressful and sometimes life-changing. Taking early action to build a portfolio of evidence of targeted professional development can be critical to ensuring a positive outcome. This is why, for most cases, Dental Protection offers extensive, targeted and personalised remediation advice at an early stage of an investigation as one of the many benefits of membership.

Dental Protection's support includes practical information about working with and populating a targeted personal development plan (PDP), writing reflections on learning needs and actions, using audit to improve quality and signposts to a wide range of blended learning opportunities. Advisers from the remediation team offer one to one feedback and support throughout the course of an investigation (and during a period of 'conditions') as appropriate.

The authors are correct in pointing out that the dental defence organisations' education teams provide relevant learning material. We take an 'upstream' approach to risk management and many Dental Protection members take advantage of our range of free risk management workshops held throughout the UK.

Most importantly, Dental Protection values and welcomes a collaborative approach with PgDTs on behalf of its members and it is for this reason we advise and encourage our members to make early contact with their Deanery to evaluate or further develop their PDP. On occasions, members have reported that it is sometimes difficult to establish contact with the appropriate person at the Deanery as processes appear to vary from deanery to deanery. We are also sympathetic to the challenges that stem from financial constraints and recognise that this may necessitate the introduction of charges for additional mentoring services.

Finally, we welcome the report's focus on psychological support for some DRiD. I am pleased to say that Dental Protection recognised the value of this some years ago and offers a free and confidential counselling service (from an independent provider) for members who feel they would benefit from it.

R. Rattan,
Dental Director, Dental Protection

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