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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

Look at Sweden

Sir, I believe things can be changed about the way in which claims are made against dentists today. Solicitors have had this money-spinning job for a very long time. Sadly, the tendency in the UK today is that patients are encouraged to sue dentists. This is of immense concern and we dentists and the BDA should do something about it. Today, you can find solicitors that advertise in order to encourage people to sue a dentist. I heard someone say 'Great, my solicitor said that I can sue that damn dentist and finally I can buy myself a new car'. Why have indemnity policies that will make solicitors and dental indemnity policy providers richer and the dentist indemnity policy more expensive? Why is there no one in the BDA that argues for a change – when every dentist that I have met says the same thing 'the UK is getting more and more like the USA'?

Why not look at Sweden, with a different kind of compensation for patients. First of all, if a patient is not happy, the case is sent to a local panel (the patient's identity and the dentist's name are withheld) who will agree upon a solution (with little compensation). If the dentist concerned is not in agreement, the local panel will send this to the national panel, where specialists and dentists will take the final decision. This means that two separate groups of dental experts have judged the case, therefore a solicitor would not try to take it to court, since it has already been fully evaluated. If the dentist does not follow the national committee's decision, the dentist will be struck off, ie be prevented from practising or have a very difficult time trying to practise. This differs to the UK in that the dental indemnity in Sweden is in principal controlled by the Swedish Dental Association. This system ensures that the patient will have the correct treatment and that the cost is kept at minimum. In summary, why cannot dentists help dentists; why must the UK be so different, when all dentists would benefit from a different system? Why cannot the GDC or the BDA invent local panels with this function and give the dentists involved CPD points for assessing cases? This would encourage dentists to join panel meetings (another way to gain CPD points). To be honest, I don't believe that this is likely to happen in the UK, since solicitors seem to be closely related to indemnity policy providers. Imagine what would happen if the millions of pounds that are spent on legal costs were invested in postgraduate training and to support the local/national panels. Ask yourself 'why do I pay solicitors in order to correct a dental problem, when it should be addressed and corrected by a dentist?'

J. Carleson
Torquay
doi: 10.1038/sj.bdj.4813569

Higher moral ground

Sir, I have recently received the spring issue of the *GDC Gazette*, which contains several pages of conduct cases, each report given in prurient detail with the miscreants stripped of their courtesy titles. Contrast this with the similar publication from the General Medical Council. They generally select one case per issue and grant the practitioner concerned anonymity.

Which body, I wonder, considers itself to hold the higher moral ground? There are other differences too. The GMC only charges medical practitioners £290 per year; the GDC charges £409 despite the fact that dental incomes are far lower than those of medical practitioners. Finally, medical practitioners can remain registered free of charge after the age of 65 whereas dentists have to pay and maintain our CPD in order to do so.

J. Ludford
Salisbury
doi: 10.1038/sj.bdj.4813570

Drug management

Sir, in response to Dr Harrison's letter (*BDJ* 2006; **200**: 242–243) requesting evidence based protocols for patients prescribed bisphosphonates, I would refer those managing these patients to the recent review article by Hellstein and Marek in the *Special Care Dentist*.[1] There have also been recommendations made by an expert panel established by Novartis (manufacturer of pamidronate disodium (Aredia) and zolendronic acid (Zometa)). These can be found at the US Food and Drug Administration website.[2] For the convenience of colleagues, I have summarised the management protocols.

The major treatment paradigms for patients treated with nitrogen-containing IV bisphosphonates, (prescribed for hypercalcaemia of malignancy, metastatic cancers and multiple myeloma, eg Aredia and Zometa) are:

1. To achieve a high degree of dental health prior to therapy
2. Preventive dental education and routine recalls
3. Practitioners should try to avoid chronic trauma to any portion of the biological width (composed of three approximately 1 mm intervals of sulcus, junctional epithelium and connective tissue) and acute trauma within 1 mm of the alveolar crest or submucosal bone.

Management suggestions are prior to initiation of chemotherapy, immunotherapy and/or bisphosphonate therapy:

- A similar exam as given to patients undergoing head and neck radiation
- Panoramic baseline radiographs to optimise detection of pathological processes beyond the alveolar process, periodontal and endodontic status of remaining teeth
- The patient's oncologist should be consulted to determine any modifiers such as patient life expectancy
- The dentist should project at least 10 years into the future when planning the prognosis of teeth and periodontal health
- The treating oncologist in consultation with the oral maxillofacial surgeon or other dental specialist may consider delaying bisphosphonate treatment to permit dental management
- Teeth with guarded prognosis should be extracted and bone surfaces covered with epithelium
- Tooth extractions, mucoperiosteal flaps and intramedullary bone manipulations should be performed three to eight weeks prior to therapy
- Dental prophylaxis, caries control and stabilising restorative care, placing the margins of restorations clear of the gingival sulcus
- Examine dentures to ensure proper fit
- Oral hygiene instruction.

Once therapy has been started:

- Regular oral assessments every three to four months
- Educate patients with regard to the

importance of good dental hygiene and symptom reporting
- Perform routine dental cleaning. Management of periodontal disease is necessary to prevent disease progression
- Check and adjust dentures
- Restorative care, not violating the biological width, may be performed
- Tooth extractions should be considered as a last resort
- Non-surgical endodontics should be performed, even if the tooth is non-restorable, instead of extraction
- Intrabony biopsies should be avoided unless diagnosis of metastatic disease necessitates such a procedure
- Implants and other elective procedures which penetrate through the mucosa and into bone are contraindicated
- The least traumatic procedure should be performed to treat emergencies.

Patients prescribed nitrogen-containing oral bisphosphonates (for osteoporosis and Paget's disease of bone, eg Actonel) are thought to be at lower risk of osteochemonecosis. The major treatment paradigms for patients exposed to oral bisphosphonates, are:

1. To identify patients at risk through comprehensive medical history
2. Preventive dental education and routine recalls
3. Practitioners should try to avoid chronic trauma to any portion of the biological width and acute trauma within 1 mm of the alveolar crest or submucosal bone
4. When the biological width is violated topical antimicrobials eg chlorhexidine are indicated for two months or longer if the area remains inflamed, erythematous or irritated.

Management suggestions are:
- Do not recommend discontinuation of oral bisphosphonates to reduce risks of osteochemonecrosis
- Combine excellent oral hygiene and routine dental care
- Perform procedures so as to minimise intrusion into the biological width
- Devise treatment plans which minimise surgery
- If the biological width is going to be violated, treat one tooth or sextant first allow for a two month disease free follow-up before treating other teeth
- Areas of periapical pathology, purulent periodontal pockets etc are of themselves a risk for osteochemonecrosis and should be addressed
- Particularly high risk procedures such as implants should be carefully evaluated. Particularly intrusive or complicated procedures may be ill-advised
- The routine use of systemic antibiotics as a preventative measure appears unnecessary unless required for other reasons eg cardiac disease.

Colleagues managing these patients would be strongly urged to look up the references below for further background and details.

R. Baker
Paignton

1. Hellstein J, Marek C. Bisphosphonate induced osteochemonecrosis of the jaws: An ounce of prevention may be worth a pound of cure. *Spec Care Dentist* 2006; **26**: 8-12.
2. Novartis Pharmaceuticals, Corporation. Expert Panel Recommendation for the Prevention, Diagnosis and Treatment of Osteonecrosis of the Jaw, 2005. February 1 Appendix 11 www.fda.gov/ohrms/dockets/ac/05/briefing/2005-4095B2_02_12-Novartis-Zometa-App-11.htm

doi: 10.1038/sj.bdj.4813571

No evidence

Sir, Dr Harrison (*BDJ* 2006; **200**: 242–243) asks about management of bisphosphonate-related osteochemonecrosis. Three bisphosphonates, pamidronate (Aredia; Novartis), zoledronate (Zometa; Novartis), and alendronate (Fosamax; Merck) have been linked to this painful problem that can affect the jaw bones. There certainly are no evidence-based management protocols.

Probably the most comprehensive work on the subject is by Robert Marx, in a paper that concludes 'Complete prevention of this complication in not currently possible. However, pre-therapy dental care reduces this incidence, and non-surgical dental procedures can prevent new cases. For those who present with painful exposed bone, effective control to a pain free state without resolution of the exposed bone is 90.1% effective using a regimen of antibiotics along with 0.12% chlorohexidine antiseptic mouth'.[1] As far as I am aware, surprisingly there is no evidence that cessation of bisphosphonate therapy helps once the condition has arisen.

C. Scully CBE
By email

1. Marx R E, Sawatari Y, Fortin M, Broumand V. Bisphosphonate-induced exposed bone (osteonecrosis/osteopetrosis) of the jaws: risk factors, recognition, prevention, and treatment. *J Oral Maxillofac Surg* 2005; **63**: 1567–1575.

doi: 10.1038/sj.bdj.4813572

Bisphosphonate guidelines

Sir, in reply to the request from Z. Harrison for evidence-based protocols dealing with the problem of bisphosphonate-associated osteonecrosis (*BDJ* 2006; **200**: 242–243), I am afraid that there are no randomised trial results at present. However, an excellent comprehensive review paper was published in the December edition of the *Journal of the American Dental Association* and this should be essential reading for all dentists.[1] Their observations included the following.

Bisphosphonates are used to treat resorptive bone diseases and to control bone loss in malignancies such as multiple myeloma and metastatic solid tumours. They act by inhibiting osteoclastic activity and therefore severely compromise normal bone deposition and remodelling. The complication of bisphosphonate-associated necrosis (BON) associated with their long-term use has recently been recognised although the exact mechanism which leads to this condition is still unknown.

BON has been reported with the use of the intravenous agents pamidronate (Aredia) and zoledronic acid (Zometa). The most common history is lack of healing following dental extractions, although other dental procedures have been implicated. The oral lesions are similar to those of radiation-induced osteonecrosis and are often progressive, leading to extensive areas of bone exposure. Since there is no successful therapy at present, prevention is of vital importance.

All patients about to begin bisphosphonate treatment and those who have recently started should undergo a full dental evaluation in order to achieve an excellent state of dental health and eliminate all potential sites of infection. Periodontal therapy and restorative procedures should be provided and any extractions completed as soon as possible. Following active treatment, there should be regular visits for oral examination and reinforcement of oral hygiene measures.

For patients who have developed BON, routine dental care may be provided but scaling and prophylaxis should be as atraumatic as possible. Ideally extractions should be avoided, except in the case of very mobile teeth, and endodontic treatment considered. Any extractions should be performed with the minimum of trauma and patients should be followed up weekly for the first four weeks and then monthly until the sockets are completely closed and healed. Where antibiotics are indicated, amoxicillin alone, or in combination with clindamycin, may reduce the incidence of local infection. The area of BON should only be treated with the object of eliminating trauma from sharp edges of bone. A chlorhexidene mouthrinse is recommended four times a day and any odontogenic infections treated aggressively with systemic antibiotics. It is important that any prosthetic appliances should fit well and these may be relined with a soft liner to prevent soft-tissue trauma and pressure.

There is no scientific evidence to support discontinuation of the bisphosphonate therapy to promote healing of necrotic tissue and this should not be done without full consultation with the patient's specialist. Since the half-life of intravenous bisphosphonates is reported to be years, cessation of therapy for a few months will

have little effect on the bone environment.

For a complete account of the problem I would advise full reading of this excellent article which may be obtained from the *Journal of the American Dental Association* website at jada.ada.org.

D. Regan
Matlock

1. Migliorati C A et al. Managing the care of patients with bisphosphonate-associated osteonecrosis. *J Am Dent Assoc* 2005; **136**: 1658–1668.

doi: 10.1038/sj.bdj.4813573

Of relevance to dentistry

Sir, in response to the question posed in Dr Harrison's letter,[1] it may be that the recent publications, quoted here, have answered it already.

'There are no guidelines based on robust evidence, clinical management of the oral complications of BON are based on expert opinion'.[2]

It is suggested in the meantime we follow protocols relating to osteoradionecrosis (ORN). One such recent publication gives some simple and useful guidance.[3] The advice given by Marx[4] would also still appear to stand:

'Treatment of established cases is recommended to begin with an identification that palliation and control of osteomyelitis are the primary goals. Control and limitation of progression has been obtained in most cases with long term or intermittent courses of penicillin-type antibiotics (erythromycins or tetracyclines if penicillin contra-indicated), Chlorhexidine mouthwash and periodic minor debridement of soft-textured sequestrating bone and wound irrigation.'

Hyperbaric oxygen (HO) is used as part of a preventative regime in cases requiring oral surgery who are at risk of developing ORN, for example given pre and post extraction of mandibular molars. The effectiveness of HO when used as an adjunct in the treatment of established (overt) ORN has recently proved difficult to support following analysis of a multicentre trial.[5] The place of HO in the prevention or treatment of BON is as yet unclear.

Intravenous administered bisphosphonates are more commonly reported in relation to the more aggressive form of the disease,[6] but the common oral administered drugs, alendronic acid (Fosamax) and risedronate sodium (Actonel) can also be associated with various levels of the condition. The emphasis at the moment is therefore very much prevention rather than cure.

Intravenous drugs Prior to therapy the highest level of oral health should be achieved.[7] During and after IV administration of the drug patients should receive regular oral examinations. Symptoms of oral pain should be explored urgently. If an extraction is considered to be unavoidable or other signs of BON present, then communication with your oral surgery/oral maxillofacial colleagues may be prudent.

Oral administered drugs These appear to be less toxic, the incidence of BON to be lower and the time to presentation of disease later than with IV drugs. The cessation of the drug in conjunction with the previously mentioned regimen hopefully will lead to resolution. However, the bone may take up to a year to return to such a state when it can more effectively resist infection. Close monitoring of all affected cases is advised long term.

The bisphosphonates are very useful drugs and are being used more and more for a number of conditions. Because of the oral side effects and complications associated with these drugs they are very much of relevance to dentistry. If our patients are receiving these drugs we need to know about it.

I hope this is of interest and some use.

N. J. Malden
By email

1. Harrison Z. Treating osteonecrosis. *Br Dent J* 2006; **200**: 242–243.
2. Migliorati C A, Casiglia J, Epstein J *et al.* Managing the care of patients with bisphosphonate-associated osteonecrosis: an American Academy of Oral Medicine position paper. *Am Dent Assoc* 2005; **136**: 1658–1668.
3. Kanatas A N, Rogers S N, Martin M V. A practical guide for patients undergoing exodontia following radiotherapy to the oral cavity. *Dent Update* 2002; **29**: 498–503.
4. Marx R E Pamidronate (Aredia) and zoledronate (Zometa) induced avascular necrosis of the jaws: a growing epidemic. *J Oral Maxillofac Surg* 2003; **61**: 1115–1117.
5. Annane D *et al.* Hyperbaric oxygen therapy for radionecrosis of the jaw: a randomized, placebo-controlled, double-blind trial from the ORN96 study group. *J Clin Oncol* 2004; **22**: 4893–4900.
6. Bagan J V *et al.* Jaw osteonecrosis associated with bisphosphonates: Multiple exposed areas and its relationship to teeth extractions. Study of 20 cases. *Oral Oncol* 2006; **42**: 327–329.
7. Melo M D, Obeid G. Osteonecrosis of the jaws in patients with a history of receiving bisphosphonate therapy: strategies for prevention and early recognition. *J Am Dent Assoc* 2005; **136**: 1675–1681.

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Child abuse referral warning

Sir, I write to you with the hope and possibility that you may raise this awareness with regard to problems I have had with a suspected case of abuse of a family of four children.

I had been seeing a family with four children for several years and over the last few years had noticed that the children had become very, very withdrawn and not connecting socially on their visits to see me. I had further noticed and observed that the father had an alcoholic problem and had seen him around the area of my practice on several occasions in a clearly drunken state. On two occasions he came to appointments with a distinct smell of alcohol on his breath.

When I recently saw some of his children for treatment I began to worry about their state of withdrawal and decided to alert Social Services, having observed this. I was aware of the fact that all professionals have

Social Services, having observed this. I was aware of the fact that all professionals have a duty to inform the appropriate authorities if there is a concern about the welfare of children but was not aware that we can make this awareness known and maintain our anonymity when making a referral. However, in this case when I made an initial enquiry with the Social Services, the family were known by the Social Services and was on a monitoring register. I was promised that they would maintain my anonymity as they said they would just re-open the case and visit the children to see how they were.

I was horrified some two months later when one of my practice staff informed me while I was away that the father had made an approach to the practice and was very verbally abusive and aggressive (I hadn't informed any of my staff of this referral). This seriously worried me as the father had been aggressive and abusive in the past and I was worried about the security of my practice staff. I immediately contacted Social Services who informed me that they'd had to tell the parents who had initiated the referral and therefore my anonymity was blown and it compromised the security of my staff as well as myself. I was informed by Social Services that the health and wellbeing of a child is far and above the welfare and security of a practitioner or his staff and premises and because of this they'd had to inform the parents who had made the referral. I was shocked to hear this and had I known this in advance I would have made another approach to the Services to try and maintain my anonymity and the welfare of my staff.

Would you kindly raise awareness through your columns that, if there is concern about the wellbeing of children, before making any referral, practitioners need to realise the implications of what happens when you make referrals under the Child Protection Act in abuse cases and that there must be some form of avenue where we can make referrals without compromise.

M. Hussain
London

Professor Tim Newton and Dr Elizabeth Bower offer some guidance: *The incident described by Dr Hussain demonstrates the complexity and difficulty of the management of suspected instances of abuse or neglect. General dental practitioners faced with a situation such as this will need to consider the welfare of the children involved, their personal safety and that of their staff. Clearly there is a moral imperative to protect the children at risk. Guidance on what to do in cases of suspected abuse is relatively clear;[1,2] practitioners can phone up and ask whether a child is on the child protection register (and if the child is on the register, the social worker will be informed of the enquiry) and/or discuss the case of a child with Social Services without disclosing the child's name. However, if they make a referral (even if this is relatively 'informal'), it is suggested that the practitioner obtains the parent's consent unless it is judged that discussing concerns with the parents would place the child at risk of significant harm. Sharing information after refusal of consent is only appropriate if the child's welfare overrides the need to keep the information confidential. Of course it can be difficult to judge the harm that may arise from speaking to a parent, and it is not a pleasant task, however a parent who is asked about their children's social withdrawal may respond differently to one who finds that they have been referred to social services without their knowledge.*

Balancing the risk of harm to the child and the risk to the staff of the practice again requires the practitioner to enter in discussions which are probably outside the normal range of general practice. Dentists and staff working in the practice will be protected by the law on assault, and practices should develop guidance on the management of threatening behaviour. A key element is communication within the team, and the development of clear guidance on dealing with problems of this nature.[2] In a busy practice setting, it is easy to hope that what are, thankfully, relatively uncommon occurrences can be managed as and when they occur. However the development of protocols for handling difficult situations can ensure that a response, when needed, maximises the beneficial outcomes and reduces the risks.

1. Department of Health. *What to do if you're worried a child is being abused.* UK: HMSO, 2003.
2. Bower E, Harrison V, Newton T *et al. The management of abuse: A resource manual for the dental team.* London: Stephen Hancocks Ltd, 2005.

doi: 10.1038/sj.bdj.4813575

First class equivalent

Sir, I was disappointed to read of Miss Westcott's experience in applying to study medicine (*BDJ* 2006; **200**: 125). It would appear that the admissions tutor was unaware of the position of the BDS in the national qualifications framework. The BDS is an honours degree but it is not classified at the request of the regulatory body. There is agreement at the University of London that those awarded BDS with honours, or with distinction, have the equivalent of a first class degree.

T. R. Pitt Ford
By email
doi: 10.1038/sj.bdj.4813576

How does it work?

Sir, I was pleased to see the excellent article by C. D. Lynch and P. F. Allen on a contemporary impression technique (*BDJ* 2006; **200**: 258–261). This technique is very useful in practice and certainly works;[1] the question is HOW does it work? The laws of hydraulics state that the liquid that is the impression material (yes, it is a liquid, albeit one in which the viscosity is changing) can only exert one pressure. So if you take a wash impression in the adapted tray, it is the same pressure over the close fitting area as over the spaced area. So why does the technique work? It is my belief that the difference in displacement in these two areas comes about because the set heavy bodied impression material touches the residual ridge and displaces it; the light bodied wash then records the distorted position. Thus this technique may produce a highly mucodisplacive impression over the heavy bodied silicone and relatively mucostatic impression over the flabby ridge. This contrasts with the Watson[2] technique which may create a true differential pressure impression at lower overall pressures. Clearly this is an area where more research is required. I believe that in specialist practice the Watson technique may still have a place. I agree with the authors that the technique they describe is very useful in general dental practice and I applaud their presentation of the technique in this paper.

T. P. Hyde
By email

1. Hyde T P. Case report: differential pressure impressions for complete dentures. *Eur J Prosthodont Rest Dent* 2003; **11**: 5-8.
2. Watson R M. Impression technique for maxillary fibrous ridge. *Br Dent J* 1970; **128**: 552.

doi: 10.1038/sj.bdj.4813577

Red wine mouthwash

Sir, I was intrigued by the article entitled Red wine good for gums (*BDJ* 2006; **200**: 245) as I have often suggested patients imagine their mouthwash is a Beaujolais. Personally I recommend just one tablet for a Beaujolais, two for a young Claret, three for a New World Cabernet Sauvignon and four for a Premier Grand Cru Classe (recommended for private patients!).

P. Williams
Lowestoft
doi: 10.1038/sj.bdj.4813578

Disappointing research

Sir, I have followed, with interest, the recent correspondence in the *BDJ* on ozone therapy in dentistry. The problem, cited both by the Cochrane Systematic Review[1] and the review by NICE[2] has been a lack of robust evidence. I was therefore attracted to the recent letter Missing the point (*BDJ* 2006; **200**: 305) in the hope that newly published evidence, not available to the above reviews, would be quoted. However, I was disappointed, as five of the seven references were abstracts from the programmes for research meetings, rather than full papers published in peer-reviewed journals. These abstracts were

dated 2003 and 2004, so I would have thought that there was sufficient time for the research to have been written up, submitted and published, despite the delays always encountered in the review and publication process. One is given to wonder, therefore, whether these abstracts failed to get into the review process or were simply not considered to be worth writing up as full papers. The dental research world is waiting for more evidence, of good quality, into a treatment (ozone therapy), which could be revolutionary. It surely is beholden to those researching the field to provide this evidence at the earliest possible opportunity.

F. J. T. Burke
Birmingham

1. Rickard G D, Richardson R, Johnson T *et al. Ozone therapy for the treatment of dental caries* (Cochrane Review). Issue 3. In the Cochrane Library. Chichester: John Wiley, 2004.
2. *HealOzone treatment for the treatment of tooth decay* (occlusal pit and fissure caries and root caries). Technology Appraisal 92. National Institute for Health and Clinical Excellence. www.nice.org/TA092

doi: 10.1038/sj.bdj.4813579

Role models in academic dentistry

Sir, O'Brien and Kay (BDJ 2006 **200**: 73-74) should be congratulated for opening the debate on clinical academics. Much of the correspondence has highlighted the negative aspects of following such a career and whilst we do not disagree with the problems over the years of dental academia, it is important to highlight the positive side. A number of those individuals who have corresponded in the letters column of the journal are very successful academics.

In all walks of life there are role models who have influenced our career progression and it is vital that clinical academics encourage others. Professor Michael Rees wrote in *Role models in academic medicine*[1] published by the BMA, 'one of the recurring themes is that in order to inspire the next generation of medical academic staff, more visible academic role models are needed.' We all remember clinical teachers who were inspirational and were passionate about their work, and dental schools should come forward to champion their teachers and researchers.

There will be many people who can contribute in many different ways to teaching and research. Some may major on teaching whilst others will be researchers, but all groups will have a common aim and that is to change the future of dentistry for the better. There are challenges to being a dental academic but these are not insurmountable and it is how the opportunities are acted upon that is important. It is possible to become disillusioned by the work load etc, and dentistry has had its fair share of self destruct mechanisms in the past. O'Brien and Kay may be wearing rose coloured tinted spectacles but what is the alternative? To lie down and die? Certainly from the correspondence that has been received this latter option is not advocated.

In response to the difficulties facing academia the Dental Academic Staff Group of the British Dental Association is holding a fringe meeting on the role of the dental academic on Friday 19 May 2006 at the BDA annual conference and everyone is welcome. We would like to use the proceedings to form the basis of a web document similar to that of the BMA. It is our opinion that where ever possible the dental profession must make young dentists aware of the opportunities available in teaching and research. It is vital for the future of the profession that new colleagues take up such careers in order to influence the future of dental academia.

The summary below is taken from the talk on the *Joy of being an Academic*.

'A job is a job but dentistry is a vocation. It is the interaction with patients and the variety of the work that makes dentistry so rewarding. It is possible to add extra value to your dentistry by being involved in both new developments arising from research and helping others to learn. Reward is a great motivator in any job or career and academic dentistry will provide it in abundance. Being an academic involves both research and teaching but also allows you to stay focused on your clinical activities. But most importantly you are in a privileged position to help the profession develop and move forward into the future.'

The job of being a dental academic does have challenges; we do have three masters to follow: clinical, teaching and research, which at times can be frustrating. However, it is a matter of looking at the glass being half full not half empty. The opportunities in academia are endless and with new funding, increasing undergraduate numbers and two new dental schools, there probably has never been a better time to be involved. Our call to all those who are thinking about an academic career is to join us now and to look to opportunities of the future and not to the past

R. Hobson, A. D. Walmsley
By email

1. http://www.bma.org.uk/ap.nsf/Content/Rolemodels

doi: 10.1038/sj.bdj.4813619

No more assistants

Sir, the legislative jigsaw relating to the new NHS contract has fallen into place over a period of time but one piece – the National Health Service (Performers List) Amendment Regulations 2005 which went on the statute books on 13 December 2005 escaped most people's attention.

Whilst the main Performers List regulations encompassing medical performance came out in April 2004, the dental implications of the amended legislation are extremely significant:

(a) Undergraduates from UK dental schools will have to undertake vocational training (VT) to obtain a place on a Performers List. They will have to take any VT job going no matter what the location as they no longer have the opportunity to become an assistant for six months before finding a VT place that suits them.
(b) Undergraduates who take house officer posts will also have to do Vocational Training or demonstrate the equivalent to a year in general practice after their house jobs to be allowed onto a Primary Care Trust's Performers List.
(c) Non-EEA (European Economic Area) nationals will have to do vocational training or demonstrate the equivalence of VT, the process of which will now be a function delegated to PCTs and Deaneries since the Dental Vocational Training Authority (DVTA) has been abolished. This means that dentists from countries such as South Africa, Australia and New Zealand who traditionally took up assistant posts and worked on the practice owners' contract numbers will not now be able to do so very easily.
(d) Those dentists who have been enticed by the Department of Health to acquire the IQE will not now be able to practise on the NHS without a further year of vocational training or its equivalent unless they were assistants working in the NHS prior to 31 March.
(e) In complete contrast anyone who was an assistant on 31 March 2006 automatically goes onto the Performers List even if they have been in the country for a short while or have no training or experience comparable to vocational training. This potentially presents a real risk to PCTs who may find themselves performance managing dentists who lack the relevant experience or skills necessary to work in the NHS in the UK.
(f) Anybody graduating from EEA countries can join a Performers List subject to the usual conditions but will not have had to do vocational training or demonstrate equivalence.

All these have huge implications for the movement and employment of dentists and far reaching consequences for manpower predictions. Add to this the increasing number of part time associates whose contracts are not being renewed by practice owners whose NHS contract value and UDA allocations are limited, and you have a serious problem in the making. Unemployment in dentistry has arrived.

L. D'Cruz
London

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