non-radiographic periodontal indices, then the clinician faces an NNT (number need to treat) dilemma which arises from research suggesting that for periapical dental radiography there is one death for every 3 million exposures.

Furthermore, the FGDP guidance on taking periapical radiographs did not extend to the same teeth in the event that a plastic restoration was to be placed. Therefore, was the guidance driven by financial concerns, in turn prompted by the need for evidence in the event of a patient complaint to a professional registration body or professional negligence litigation?

I submitted the above arguments in respect of vital teeth requiring laboratory fabricated restorations. The only counter argument put was that radiographs could identify partial necrosis (with apical involvement) in multi-rooted teeth. A search for the incidence of such occurrences found no relevant evidence but there are in turn a number of indirect counter arguments:

- Imaging of the periapical tissues using the LCPA technique could fail to identify a lesion
- The incidence of relevant post treatment pulpal necrosis would appear to be low (PMID: 12473995) where a low trauma technique is used
- The radiographic NNT would appear to be potentially very high to identify each lesion. Therefore both the radiological risk and financial costs are likely to be very high for each identified case
- Where necessary, RCT through the restoration is likely to be successful
- A retrospective study to determine the incidence of such lesions in vital teeth is feasible and potentially less fraught than undertaking an appropriate double blind study to resolve the issue given the potential difficulties from both clinical and ethical perspectives.

Therefore, rather than focusing directly upon comparing outcomes with and without radiographs, I believe that the evidence base dilemma could be substantially addressed by an indirect evidence-based approach. This involves calculating the overall probability of adverse findings additional to those which can be ascertained without using ionising radiation and then assessing the potential value of the additional clinical evidence which the most potentially appropriate radiograph can provide and its associated risks. While this is currently applied implicitly, formal scientific assessments would appear to be indicated.

I understand that these arguments may contribute to a revision of FGDP(UK) guidelines but my PCT and the DPD have accepted them for not taking radiographs for vital teeth which are to be restored with laboratory fabricated restorations.

P. Mc Crory, Radcliffe

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CURRICULUM CRUTCH

Sir, having recently returned to dental school after studying medicine, the importance of the hidden curriculum has never been so obvious.

Before, throughout, and indeed after medical school, during postgraduate training, the hidden curriculum was my crutch. Be it relatives or family friends with their hyperparathyroidism, or Duke's B Colorectal carcinoma, *ER*, *Casualty*, *Sunday Surgery*, glossy magazines, the tabloids, recounting stories with my friends, witnessing signs of disease on public transport and *Panorama*, I was never far away from someone or something that would reinforce my knowledge or inform my clinical practice.

Dentistry is a different kettle of fish. Although it is much easier to appreciate a cavity, restoration, or a gum boil on a friend or family member than perhaps carry out a colonoscopy in the living room, it is not easier to appreciate the finer aspects of dentistry through this method.

ER and *House* are of little help. There is no revision of the properties of elastomeric impression materials in the Sunday papers. I won't come across the morphology of the deciduous teeth on the London Underground. There will be no undercover investigations into oral bullous disease.

In terms of the hidden curriculum, medicine is like being a newsreader with an autocue. Dental students must be aware of this difference, although some of the attidudinal and communication concepts do translate, I will need to look elsewhere for my autocue this time around.

T. W. M. Walker, London

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PRECAUTIONARY PRINCIPLE

Sir, I have been in correspondence with my local MP regarding HTM 01-05 since last year. It has been difficult to make any headway in constructive argument, as there appears to be a policy approach from which the Department of Health will not waver, but I have managed to extract some interesting points.

A letter I received in April 2010 from the Department of Health comments: 'A balance therefore has to be struck between protecting against these risks, the cost of protective measures, and the practical constraints that the design and structure of many dental practices put on the accommodation of new equipment and the adoption of new practices – the so-called precautionary principle.' One wonders where the precautionary principle could start or end?

On pressing further a letter signed from Earl Howe on 25 June 2010 states, 'that best practice may be impossible to implement without relocating some practices.'

After pressing for more information of any audit into the costs and practical implications of so-called 'best practice', I was handed over to 'Customer Services' at the Department of Health. Customer services stated in their letter: 'The Department accept that these standards will have significant implementation costs for some practices with perhaps a small minority only capable of complying by acquiring new practice premises.'

If your practice cannot comply, would it mean your practice would have to close? Sadly I have been made aware of two local dentists who are now filing for bankruptcy.

What would Sir Philip Green have to say about this policy considering he thought the information held about what the Government spent on services was so sketchy that if his business was run in that fashion 'the lights would go out'?

D. Griffiths, Radlett

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