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.

NATURAL DISASTERS

Offering help

Sir, as a consequence of the increasing number and urbanisation of the world's population it is estimated that the number of people affected by natural disasters will rise from the current 250 million people per year to 375 million by the year 2015.[1] Against this backdrop of increasing need there are very few organisations that can assist individuals who feel that they would like to offer their help. Many of the well-known charitable relief organisations require a lengthy time commitment and most consultants working for the NHS are unable to offer this.

I have launched a charity 'FaceFacts' (Scottish Charity number SC 042622), one of the aims of which is to help individuals donate short periods of time to working abroad in the developing world. This may be as part of a team mobilised for disaster relief or may be more formally arranged educational/operating visits. The charity also aims to share knowledge and skills with oral and maxillofacial surgeons across the world. As well as organising overseas visits, the charity would also encourage foreign surgeons to come on funded observerships to units within the UK.

All volunteers would provide their time *gratis* and trips would usually last only one or two weeks at a time. If there are any maxillofacial or oral surgical colleagues who would like to donate either time or money to help or register for emergency disaster relief then please contact me at facefacts7@btinternet.com.

S. Laverick
Consultant maxillofacial surgeon, Dundee

1. Department for International Development. Humanitarian Emergency Response Review. 28 March 2011. Available at: https://www.gov.uk/government/publications/humanitarian-emergency-response-review (accessed 19 March 2014).

DOI: 10.1038/sj.bdj.2014.254

DENTIST SUICIDES

Speculation and myths

Sir, I was interested to read Stephen Hancocks' recent editorial *Taking a life* (*BDJ* 2014; **216:** 47) on the very sad topic of suicide. As he remarks, 'frustratingly perhaps there are a variety of opinions, much speculation and lots of myths'.

I thought Stephen might be interested in an early paper entitled *Mortality and occupational diseases of dental surgeons.*[1] This paper too acknowledges the myths that surround the statements about the health problems of dentists and the difficulty in compiling accurate statistics. Apart from a brief mention that 'suicide is reported as being very frequent among medical men, and dentists are nearly as bad' the paper doesn't go into any further details on this topic. It concentrates on what it regards as the four classes of occupational diseases affecting dental surgeons – those related to posture, those due to infection, those associated with the nervous system and those due to drugs. Whilst recognising the stresses arising from dealing with patients and with those 'irritating moments when things go wrong', the author is happily able to conclude that 'ours is a healthy occupation. We are leading a life which is not fraught with danger and which should not incapacitate us unduly and preclude the possibility of a healthy old age'.

Interestingly, the writer paid special thanks to Lillian Lindsay, who by then was Hon Librarian of the BDA, for the help she provided with references and statistics.

The paper[1] was given by Cyril H. Howkins as his presidential address to the section of odontology at the RSM on 28 October 1935.

J. Papworth, by email

1. Howkins C H. Mortality and occupational diseases of dental surgeons: (Section of Odontology). *Proc R Soc Med* 1935; **29:** 35–39.

DOI: 10.1038/sj.bdj.2014.255

ETHICAL DILEMMAS

Guidelines without context

Sir, a patient attended a dental practice in the mid-1990s as a new patient for ongoing care. The long-term risks of inadequate plaque control were consistently stressed by Dentist 1 over a period of ten years during which the poor condition of the gums were noted and shared with the patient on numerous visits. Dentist 2 then saw the patient for three years for ongoing care with similar emphasis on poor gum condition and strategies to rectify this, during which the reality of worsening gum health was shown to the patient with advice as to how to halt this process. Dentist 3 then saw the patient and again stressed the importance of self-help in the control of the worsening periodontal condition. The three clinicians concluded that referral for specialist care without commitment to self-help was inappropriate: 'owning' their decisions as 'gatekeepers'.

Eventually an anterior tooth became mobile causing a problem for the patient who was again seen by Dentist 1 who emphasised plaque control measures but presented the reality of tooth loss.

The patient then attended another practice for a second opinion. Dentist 4 correctly diagnosed advanced periodontal disease but the patient claimed that she had not received any information regarding plaque control at the previous practice. In the absence of historical notes and on Patient A's word, advice was to given to take the case to the Dental Law Company (recorded on patient notes). Dentist 4 referred Patient A to a specialist, Dentist 5, who also presented a full case history demonstrating advanced periodontal disease and a treatment plan that involved costly implant therapy. A legal process began which resulted in settlement out of court without any admissions of fault, as this was the most cost effective pathway. This resulted from the note keeping (although extensive and collaborative with the patient) of Dentists 1, 2 and 3 not conforming to the guidelines issued by the Royal College Faculty of General Dental Practitioners.

Applying guidelines without contextual consideration places the clinician in the position of being a technician conforming to rules without the ability to use professional judgement in individual circumstances. There are many circumstances where the acceptance of periodontal disease is an only option, for example in an individual who is compromised in the ability or willingness to control plaque. This professional

© 2014 Macmillan Publishers Limited. All rights reserved