Please note that all letters must be typed. Priority will be given to those that are less than 500 words long. All authors must sign the letter, which may be shortened or edited for reasons of space or clarity. All letters received are acknowledged.

Research discredits rebel dentists

Sir, — Recently the national newspapers have been full of reports previewing the Channel 4 dispatches documentary *Tooth Trouble*. This programme was based on the misguided views of a small but vocal minority of 'rebel' dentists.

The claims of these so-called 'rebel' dentists were commonly heard in orthodontics many years ago and in the absence of evidence there was genuine controversy. Since then the research has been done, and in every instance the claims of the rebels have been refuted. There is now plenty of robust evidence to show that: —

- Contemporary orthodontic treatment does not harm profiles.
- Orthodontic treatment of any sort scarcely affects growth of the jaws or face, indeed functional appliances are just a convenient way of moving teeth.
- Orthodontic treatment neither causes nor cures problems such as headaches or locking of the jaw joints.
- Expansion of the dental arches is prone to relapse.

The orthodontic community has responded to these studies and provides treatment to its patients based on the best contemporary evidence. The 'rebels' wish to drag us back into history.

J. Sandler
Chairman BOS Media Committee

Questions raised in anaesthesia debate

Sir, — I read with interest the paper by G.L.Tyrer, *Referrals for dental general anaesthetics — how many really need GA?* (*BDJ* 1999; **187:** 440-444).

While I am sure it is possible to treat most children under local anaesthetic for most procedures, it must be realised that certain procedures and certain children are impossible to treat any other way than with the use of general anaesthetic carried out in recognised centres with adequate facilities. Many practitioners spend many hours of their time gaining their patient's confidence which will allow them to carry out 'routine' dental care and then refer the child on for general anaesthesia for exodontia in a recognised centre. If the patient then requires extractions in more than one quadrant or extractions where there is local sepsis which will interfere with the efficacy of local anaesthesia, it is not unreasonable to opt for the general anaesthetic approach rather than traumatise the child with multiple injections and possible inadequate anaesthesia.

I agree that where at all possible general anaesthetics should be avoided but feel Mr Tyrer returns patients to their general practitioner having undone a lot of the good that careful, long-term and patient rapport has built up. He sees them for one or two treatment episodes whereas the general practitioner has to then spend more time and effort to coax the child back into routine dentistry. Similarly, the often quoted no general anaesthetic for orthodontic extractions needs to be addressed. I appreciate that orthodontic extractions are purely elective and that there is no predisposing pain or sepsis involved in the reason for their extraction. However, a child who has never been exposed to any form of interventive dentistry and is then subjected to the extraction of usually at least four permanent teeth at the age of 12-15 years, be they premolars or second molars, is bound to feel some further apprehension of future treatment, particularly if the extractions are carried out in stages.

I note from the Table 1 in his paper that one child had 'assessment and some treatment for orthodontic extractions.' I wonder what became of the further treatment required or were they returned to the general practitioner 'half done'? He also surveys parental satisfaction. What about patient satisfaction? Surely it is the child's post-operative opinions that are important.

Once again the very people who should be advocating safe usage of general anaesthesia are turning against it and in my opinion creating the dental phobic patients of the future.

P. N. Liston
New Zealand

Sir, — Whilst firmly supporting the strict limitation of general anaesthesia for dental treatment to those patients and clinical conditions where there is no alternative, certain aspects of the recent paper by G. L. Tyrer (*BDJ* 1999; **187:** 440-444) raise a number of questions.

The establishment of a pre-anaesthetic assessment clinic is welcomed but it is noted that referring practitioners were informed of the outcome in a 'standard letter' only after the completion of treatment even where there may have been a significant change in the initial plan. Is it prudent for a clinician in the privileged position of having been referred a patient by a professional colleague then to unilaterally change a suggested line of management and even execute it without initially discussing or even informing the referring practitioner?

Where it is felt after further consideration that treatment under local anaesthetic is an option, might is not be reasonable to involve the referring colleague to determine whether he or she may wish to complete it? Would this not maintain the continuity of care crucial in the development and maintenance of a young child's confidence as well as that of the parent in the all important professional relationship with the dental surgeon?

It is stated in the paper that the 'assessment of parental satisfaction' was carried out by 'Community Health Council personnel' (CHC) and that a 'set question' was asked. The close involvement of the CHC as an independent assessment body is to be applauded. However, we are not informed in the paper how many people asked the question and rated the responses. If more than one there must be a risk of observer variability in a highly subjective assessment on a scale quoted as 'very positive to very negative'. It would be more reassuring to have seen in the paper the text of the 'set' question and the criteria applied in grading the response, especially as they all were recorded between 'very positive' and 'neutral' with none at the 'negative' or 'strongly negative' end of the scale?

One is also anxious that 'there was an initial presumption against the use of general anaesthesia' even though a patient had been referred with a view to this by a professional colleague. Is it good practice to approach any clinical problem with a pre-conceived notion? Can any of us be so sure about our case selection abilities to state that there is no 'need' when another colleague's clinical judgement has suggested that there may be? Clearly the points highlighted in the review by Mr Alex Crawford (*BDJ* 1999; **187:** 431). that 15% in the series 'failed to complete' treatment and that the telephone sample was merely 46% of the series suggests not.

Is is essential that appropriate selection criteria for general anaesthesia are fully applied and that subsequent administration is in the safest possible environment. However, it is also important that the professional judgement of the clinicians involved is carefully balanced. In addition, at this very important time in the evolution of general anaesthetic practice in dentistry any papers on the subject must have proven validity.

J.C. Lowry
Bolton

The author responds: *I would like to thank Mr Liston and Mr Lowry for their comments.*

Mr Liston makes the point that 'certain procedures and certain treatments are

impossible to treat any other way than with the use of general anaesthetic.' I could not agree more, and when he states that 'it is possible to treat most children under local anaesthetic for most procedures' he puts my position almost as succinctly as I do myself.

The empirical criteria for selection of patients for DGA that I described in my paper recognise and take account of both the scenarios he describes: where local sepsis may preclude adequate analgesia; and where multiple treatment needs might be unacceptable as awake procedures. We would appear to be in accord, therefore, on those matters as well.

I am disappointed and somewhat hurt that he implies that, by my intervention, I return patients to their general practitioner 'having undone a lot of the good that careful long term and patient rapport has built up.' I wonder on what evidence he bases such assumptions.

I would, however, agree that, regrettably, there can sometimes be a degree of ground to be made up by the child's own dentist when extractions have been completed in the type of situation he describes, but is he seriously suggesting that this never happens after DGA? I have to say that the impression I have formed from my own considerable experience of taking histories from adult and child patients who present as dentally phobic, is that they recount horror stories of frightening DGA experiences at least as often as they refer to things that occurred during awake episodes of treatment.

Mr Liston states that general anaesthetics should be avoided where at all possible, but I wonder whether he really means this. One cannot accidentally give a GA, so it is always possible to refuse. I have put forward examples of circumstances when it may not be reasonable to refuse, and it would appear from his earlier comments that really, he agrees with me. For the record, my position is that DGA should be avoided where it is reasonably possible and in my text I have alluded to circumstances where to refuse a GA would, in my view, be unreasonable.

Mr Liston states that children who have staged extractions are 'bound to feel some further apprehension'. Where is his evidence for this statement ? He offers no supporting arguments, but nonetheless offers it as if it were an established fact. Again, if it is his personal opinion, he should say so, but presented as it is, as if it were indisputable fact, does him some discredit, in my view.

Whilst I would not take issue with the view that some children may find staged extractions over multiple visits unacceptable, I dispute that this is inevitable as Mr Liston would have us believe. I have offered some evidence to show the contrary view — that some children not only tolerate multiple visit, staged extractions, but also, find is very acceptable. I am sorry if this challenge to Mr Liston's conventional wisdom is inconvenient for him, but I believe that in presenting my information, I have posed legitimate questions for aIl of the profession.

In asking whether it may have been more appropriate to canvass the opinions of the actual patients rather than their parents, Mr Liston raises a very interesting point. Given that some 72% of the subjects in the study were aged 8 years or under, I felt it was more appropriate to canvass opinion from the parents who would, after all, be the decision makers when it comes to agreeing and consenting to dental treatment and the adjuncts used to deliver it for others in the same position.

I share Mr Liston's fascination to know how the children themselves felt about it all. It would have been very difficult to capture the information given the constraints which applied to this study, but I am grateful to him for his suggestion. I do not suppose, however, that he is seriously suggesting such very young children would be in a position to make informed choices on such matters. However, I would not wish to discount entirely that they might contribute to the overall process.

Secondly, I am grateful to Mr Lowry, who has highlighted an ambiguity in my text. I was always mindful of the relevant GDC guidance (currently paragraph 3.4 of Maintaining Standards) stating the need to discuss with a referring dentist any proposed changes to requested treatment. In those cases where it was necessary to communicate changes to the requested treatment, the standard letter to which the text refers was sent before treatment in all cases except a very few where immediate clinical need dictated otherwise. The latter contained my alternative proposals and offered an opportunity for the referrer to phone me. None of the referring dentists took this opportunity. This is not made explicit in the text and I welcome the opportunity to clarify it now and to demonstrate the lengths to which I went in order to try to comply with the relevant guidance.

I am also grateful for the chance to further clarify the role played by the CHC. I have inadvertently incorrectly stated that the CHC organised the canvassing of parent satisfaction. In fact, the role of the CHC was restricted to their making available the telephones and in assisting with a number of the calls. To answer Mr Lowry's point, however, there were two canvassers, both experienced at telephone canvassing, working in adjoining rooms and writing down the responses obtained as they spoke. I am very happy to make available to Mr Lowry the verbatim responses referred to in the text, should he wish to see them.

Whilst the points he makes about the deficiencies in scientific method relating to the canvassing of parents' views are noted, I wonder if he has made the mistake of reading more into it than is prudent. It is important to realise that the gathering of parents' opinions is not offered as any sort of scientific survey — it was canvassing of opinion and no more. Its value is, therefore, limited to that of gaining an impression of how people felt about their child's clinical management. I have acknowledged many of its deficiencies in the text.

As to the point of whether or not it is valid to have a presumption against the use of GA, I have to refer Mr Lowry to my text where I have quoted the covering letter issued by the GDC in November 1998. That letter refers to a necessity for there to be an 'overriding need' for GA. If this, and the whole subsequent tone of the revised guidance is not sufficient to justify all clinicians having an initial presumption against GA, then I don't know what more Mr Lowry would ask for.

Mr Lowry seems to take issue with the fact that I have presumed to question the clinical judgment of other practitioners. I would argue that I have exercised my own responsible judgement as required of me by the GDC guidance at paragraph 3.4. 'The treatment requested should only be provided where this is felt to be appropriate'.

I suggest that I, and others, have demonstrated that a significant proportion of requests for DGA may not be appropriate since we have clearly shown that DGA has often not been necessary. This being the case, I would also suggest that any dentists who fail to exercise their own judgement (in these or any other clinical matters), but accept without question the judgement of others, thereby abrogate the professional duty required at the said paragraph.

I do not claim to have the only correct answers on this subject, but I do take my professional and ethical responsibilities to individual patients, to the wider public and to my professional colleagues very seriously. I also try to put into practice the very clear guidance of the DOC on these matters.

I am sorry if Mr Lowry is uncomfortable with the idea of colleagues' professional judgement being questioned. I submit that GDC guidance not only makes such questioning legitimate, but in fact requires it as a professional duty. I feel that there is a growing body of evidence to show that, at least in respect of referrals for DGA, there may be good reason for the GDC to take such a position.

Within the context of the current high profile coverage of the unfortunate events of Bristol, I am amazed that anyone in our profession might still hold a view that the clinical judgement of professionals should be considered unimpeachable and I hope that this is not what Mr Lowry is suggesting.

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