Letters to the Editor

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COMPLIANCE OUT OF FEAR

Sir, we read with interest the paper by Soheilipour *et al.* on the views of professionals on the NICE guidelines (CG64) relating to antibiotic prophylaxis for cardiac patients.[1]

We recently completed a survey of 162 dentists in the West Midlands about their views of NICE CG64.[2] We agree that we should treat our patients on a one to one basis and take into account their wishes and needs, as these current NICE guidelines state clearly '*treatment and care should take into account patients' needs and preferences. Patients should have the opportunity to make informed decisions about their care and treatment*'.[3]

However, we found that most of the dentists we surveyed were not happy to consider patients' preferences: 90% preferred not to administer antibiotic prophylaxis even if patients insisted that they should be prescribed. Fifty-two percent of the respondents felt that the guidelines from the American Heart Association would better serve their patients' interests.

Soheilipour *et al.* highlighted an important issue, that guidelines should be seen as recommendations rather than protocols. The majority of the dentists in our study were convinced that deviating from the guidelines may result in litigation and disciplinary proceedings. There appears to be a need for a fundamental debate about the rule of guidelines in determining clinical practice and this situation provides a good example of the dilemma faced by dentists in applying national guidelines to every day clinical practice.

Further we note there is a difference in emphasis given by the two main defence organisations regarding this issue. Dental Protection states that '*Dentists working within an NHS contract are required under the terms of their contract to observe the guidance of NICE when writing prescriptions. Clinicians working privately may not have contractual obligation to follow the guidance, but they would need a very strong justification for choosing not to do so*'.[4] The Dental Defence Union advises members to be aware of the current guidance, but if they judge it is in the patient's clinical interest not to follow advice contained in national guidelines, they will need to make a careful record of their reasons for doing so. They further advise that if a dentist is later called upon to justify a decision to prescribe or not prescribe a prophylactic antibiotic, he or she would have to be able to establish that they were working in accordance with a reasonable body of dental opinion.[5] Thus we wish to draw attention to the question of what constitutes a reasonable body of dental opinion, when compliance appears to be done more out of fear of adverse personal consequences than anything else.

E. Beshara, B. Speculand, Birmingham

1. Soheilipour S, Scambler S, Dickinson C *et al.* Antibiotic prophylaxis in dentistry: part I. A qualitative study of professionals' views on the NICE guidelines. *Br Dent J* 2011; **211:** E1.
2. Accepted as a poster, British Association of Oral Surgeons conference. London, September 2011.
3. NICE Short Clinical Guidelines Technical Team. *Prophylaxis against infective endocarditis: antimicrobial prophylaxis against infective endocarditis in adults and children undergoing interventional procedures.* London: National Institute for Health and Clinical Excellence, 2008.
4. Dental Protection. Position statement. Antibiotic prophylaxis. Issued 24 March 2008.
5. Harvey B. *New guidance on antibiotic prophylaxis.* The Dental Defence Union, 2 April 2008.

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CONTRARY TO JUSTICE

Sir, we write to express our unhappiness at the decision to withdraw Seniority Payments to dentists working in the General Dental Services over the age of 55 from 1 April 2011 who, we understand, will no longer be admitted to the scheme. We would like to state that we find this action reprehensible.

Monies supposedly allocated to this payment have been 'top sliced' from fees paid to all dentists working in the GDS for many years. The action of the DH to remove this payment without any form of replacement is, in our opinion, contrary to natural justice.

If we, as dentists in the GDS, were to accept payment for services to patients and then arbitrarily refuse to provide these services we would be called to account by the patients and ultimately by the relevant authorities. Prior to the introduction of the present contract we were assured that we would be operating in a 'high trust' environment. This action by the DH shows that the reality is far from this empty rhetoric.

To restore your readers' faith in the actions of the DH we would ask them to reinstate these payments immediately.

M. Buckle
Chair, on behalf of
Devon Local Dental Committee

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QUALITY MEASURES

Sir, I was extremely interested to read *An analysis of patient expenditure in the GDS in Scotland 1998 to 2007* (*BDJ* 2011; **211:** E3) by Chalkley, Rennie and Tilley. This provided an opportunity to revisit a 'fee for item of service' (FIS) contract and highlighted the tensions which I experienced as a practice owner

of a field-site with the Dental Modernisation Agency from 2002-2006.

The objectives of the practice field-site were to adopt a much more preventative philosophy in the delivery of dentistry and to this end change the skill mix within the practice, developing care pathways operating within GDC regulations which involved the therapist, hygienist and oral health educator.[1]

The FIS contract did not translate readily into our new method of working where two systems were operating contemporaneously: the fee scale from the FIS contract was still in place but the practice was given a global sum without targets attached calculated on the income generated in a six month period of our FIS contract. Those who have worked within the FIS contract will be familiar with the 'widgets' of dental treatment along with the related time bars within which one could raise a charge for certain procedures. Moving away from a delivery system no longer in tune with this method of remuneration led to a drop in patient charge revenue.

Chalkley *et al*. considered the cost of dental treatment to the patient any shortfall in patient charge revenue results in an increase in state subsidy for dentistry, and hence the taxpayer. I understand that panic, arising from financial information gathered by the Audit Commission which showed a fall in patient charge revenue across early phase field-sites, led to their early demise without proper evaluation and, in turn, to the UDA system. However, when the treatments provided within my field-site, operating to its preventative ethos, were hypothetically converted into UDAs, on my calculations, patient charge revenue was back up to the original level.

Within our site we had several measures related to our activity. From the DPB schedule we maintained the level of patient registration and if people dropped off the list within the two-year period, as they did in a very mobile catchment area, we were able to take on new patients. Together with the Modernisation Agency, a group from the field-sites developed a computer program which measured the number of contacts each patient had with the dentists, therapist, hygienist and oral health educator. At the end of each course of treatment a patient was given a numerical score which linked to the assessment of their periodontal condition and caries activity, proving an excellent oral health motivator. On a weekly basis we monitored the availability of appointments so that we had an ongoing awareness of how easy it was for registered patients to access our services. We also gathered patient feedback and gave particular attention to communicating details to patients of service changes and developments. However, the focus was on our activity and not on the patient charges that were generated.

Although I welcome the recommendations of the Steele Report, my experience does raise the question as to what system of quality measures will be implemented if the patient charge revenue is to be maintained. Clearly, whatever system is in place in the future it is important to have the patient charge revenue reliably maintained so that the contribution of the state remains constant and at a politically acceptable level.

P. Ward,
Nottingham and Plymouth

1. Ward P. The changing skill-mix: experiences on the introduction of the dental therapist into general dental practice. *Br Dent J* 2006; **200:** 193-197.

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TO SCAN OR NOT TO SCAN

Sir, my 22-year-old dental assistant complained of pain in her lower left molars. Clinical examination and a periapical radiograph revealed no obvious pathology but she felt that her lower left jaw was swelling. An orthopantomagraph (OPG) scan (Fig. 1) revealed a radiolucent variation when comparing the left *vs*. right mandible in the molar region and an apparent difference also in the radiodensity of the cortical bone of the inferior border of the mandible.

At first I considered this to perhaps reflect variation in the submandibular salivary gland depression on the lingual of the mandible inferior to the mylohyoid line. As my nurse persisted in suggesting that she felt something was wrong, CT scans of the mandible were also ordered (Fig. 2). This clearly demonstrates a significant area of pathology in the left mandibular molar region and a biopsy revealed a diagnosis of fibrous dysplasia. Treatment has been by conservative means with minimal bony recontouring and follow-up at regular intervals is planned both clinically as well as radiographically.

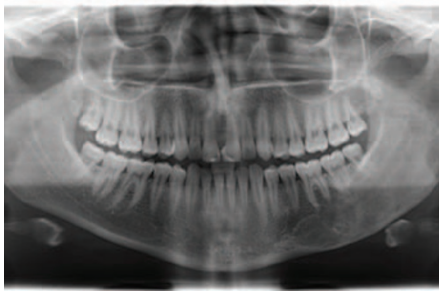

Fig. 1 OPG scan presented as facing the patient

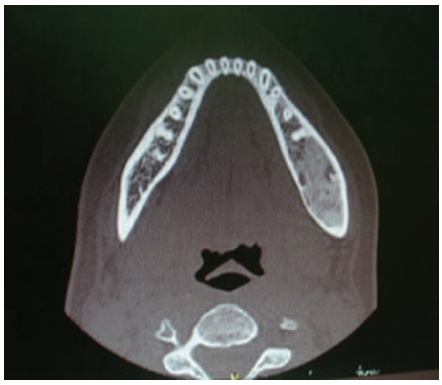

Fig. 2 Horizontal CT-mandible scan. Patient's left-side is to the right of the image

Fibrous dysplasia has been outlined as a developmental bony pathological condition.[1] It is in fact a rare sporadic condition with somatic alteration in the guanine nucleotide-binding protein, alpha-stimulating activity polypeptide 1 gene, GNAS 1.[2] Most cases, around 80%, are limited to one bone and are thus termed monostotic. These are usually diagnosed in younger individuals. Swelling of the involved part is the first sign of the presence of the disease. A 'ground glass' appearance radiographically may be seen and typical bulging of the mandibular buccal and lingual cortical plates may also be observed.[1] Close monitoring and conservative surgical reduction is usually all that is needed. Malignant sarcomatous change of the entity may occur, but this is very rare.[3] In this case, the individual suffers from thalassaemia, minor