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.

NVQ in oral health care for dental nurses

Sir,— We recently attended a talk on the NVQ in oral health care and as a result have voiced our concerns in a letter to the GDC. Are we alone in feeling that this new scheme is unworkable, or have other GDP's expressed concerns?

In our area, the cost has been estimated at approximately £600.00 per candidate, added to which of course, is the expense of providing cover for the absent member/s of staff every week. Bearing in mind the very high 'drop out' rate in respect of NVQ's the GDP will doubtless suffer further losses. In the past, we have expected our nurses to pay for the course at the outset, in order to give greater incentive to complete the course, the fee then being refunded in full, upon passing the examination. This will no longer be possible, as very few trainee dental nurses will be able to afford the fees.

The three month period of employment before the trainee has to register, is too short in order to ensure that the employee is committed to dental nursing and will 'stay the course'. This again, increases the risk of 'dropping out'.

How are those practices already on the scheme coping with staff cover? This will be a great difficulty to us, as covering for sickness and holidays is a perennial problem that I am sure we all suffer from. Having to do it on a regular weekly basis, for possibly more than one employee is a terrifying prospect!

As a practice we aim always to maintain the highest standards both for our staff and patients abiding by current legislation, laws and guidelines. We have an in-house training scheme for our staff and encourage them to take all opportunities to improve their skills and knowledge. Who checks to ensure that we abide by the high standards laid down for us to work to? In our experience no one. When it becomes legislation for all dental nurses to be registered, who will check that all practices are employing qualified/registered dental nurses only? How will this scheme be monitored?

We agree that dental nursing will be raised from the ranks of 'nice job to do if all else fails' to a more respectable status and that nurses will be able to progress academically if they achieve their NVQ 3. Dentists who have invested in the training of their dental nurses will also want to keep them and will be prepared to offer higher salaries in order to do so. I hear all dental nurses cheering here, because as we all know it has been a career where the pay rise has not compared to the responsibility of the position for too long, but it will inevitably make recruiting more difficult than it is at the moment. Is this the only way forward to ensure a general standard?

If it is to become legislation and the choice taken out of the hands of the individual, then financial support must be made available and at least some part of the cost of the NVQ must come from government funding, especially for the sixteen to eighteen year old.

We feel that the scheme has serious practical flaws, some of which we have outlined, there must be many more. We feel therefore that consultations should be conducted immediately with GDP's before the scheme is fully activated.

I. Sackett
Margate

NHS plan — proposal for new approach

Sir,— We read with interest the new proposals for consultant contracts within the NHS.[1] There appears to be an underlying implication that the period of 'perhaps seven years' of purely NHS service to be imposed (possibly illegally) upon new consultants is in some way a period of 'payback' for the training that they have received within the NHS.

Will this restriction be applied fully to our future orthodontic consultants? Let us bear in mind that when last studied in 1998 our orthodontic trainees were, and still are, paying substantial contributions towards their postgraduate training.[2] This varies locally with some trainees only receiving 50% salaries and others paying substantial course fees (eg £15,000 plus). Currently orthodontics is the only NHS medical or dental speciality to use such a system in the training of specialist registrars.

This therefore raises the question of whether our future orthodontic consultants should or should not have to complete a period of seven years purely hospital based NHS work before they can undertake private work, as they have already paid substantial contributions towards their training. Looking towards maxillofacial surgery, should newly appointed consultants have to serve seven years when they have self funded medical school places? Another debate perhaps.

M. Dixon and S. K. Derwent
Sheffield

1. The NHS Plan — Proposal for a new approach to the consultant contract. The Department of Health. Feb 2001
2. Hunt N P, Cochrane S M; Educational Supplement — Postgraduate Orthodontic Training in the UK; *BJO 1998* **25**: 4

Evolution of occlusion, past and present time

Sir,— The evolution of present-day Caucasian individuals shows that the occlusion position of dental arches has been changing over one century.[1,4,6]

This letter has been prompted by the fact that two separate populations living in south east France were studied (present-day including 82 individual and medieval from the 8th to the 17th century, including 58 individuals), the variations between teeth contacts were examined in accordance with Angle classification.

The results of Table 1 indicates that a regression of Class 3 (mesio-occlusion) was noted from medieval to present-day populations. Class 2 (disto-occlusion) developed progressively and became a general feature in the present-day population (34%). Although it is continually decreasing in both populations, Class 1 still has the highest percentage (45%) and remains a 'normal' reference in European populations.

Our results match those of Slavicek *et al*[5] which showed the same change on a current Caucasian population of 2,235 individuals, in 1983, with a parallel increase in skeletal Classes II, even more significant to 52%.

This study highlighted distal occlusion in human teeth and gave us a chance to ask questions regarding the origin of this occlusion modification in man.

Although the biomechanical forces applied to masticate and the wear generated was reduced when refined flour as well as forks became available in the 17th century, the fact that this imbalance described by Angle, also includes genetic and ontogenetic aspects of evolution characterized by our physical posture and current physiological development, cannot be omitted.[2,3] Likewise, the influence of environmental and social factors inherent to a modern and stressful lifestyle as well as the lack of parent-child bonding may generate harmful attitudes. This is exemplified by thumb sucking at a late stage and the effects this may have on the development of dental arches and the position at a late stage and the position of occlusion in children.[7] In addition, we can be reminded of the influence of a good respiration and its effects on the development of the palatal.[8]

This reflection helped place Angle classification in a dynamic human history perspective. The significant emergence of Class 2 and the related disto-occlusion in Euro-

Table 1	Frequency of distribution of Angle classification in middle ages and present-day population							
	Class 1		Class 2		Class 3		TOTAL	
Population	Number	%	Number	%	Number	%	Number	%
Medieval	25	43.1	11	18.9	22	38	58	100
Present-day	37	45	28	34	17	21	82	100

pean populations should raise questions regarding the evolution of the human race but also this letter would welcome suggestions as to the possible other aetiology of this distal-occlusion.

P. Guichard and B. Mafart
Marseille

1. Benauwt A. Etude biometrique, cranio-faciale et dentaire, d'adultes gaulois et gallo-romains du nord de la France. *Comparaisons avec d'autres populations;* Universite de Paris VI 1974.
2. Brace C. Occlusion to the anthropological eye. *The Biology of Occlusal Development.* James A MacNamara, Jr (ed.) 1977: 179-209
3. Dambricourt-Malaise A. Nouveau regard sur l'origine de l'Homme. *La Recherche* 1996; **286**: 46-54/76-79
4. Siepel C M. Variation of tooth position. *Svensk Tandl Tidsk* 1946: **39**
5. Slavicek R, Schdlballer E, Schrangl J, Mack H. Les rapports squelettiques et la comparaison dento-alveolaire. *Revue d'Orthopedie Dento Faciale* 1983; **17**: 493-516
6. Smith R J and Bailit H L. Variation in dental occlusion and arches among Melanesians of Bougainville Island, Papua New Guinea. *Am J Phys Anthropol* 1977; **47**: 195-208
7. Stone L J, Church J. Childhood and Adolescence. *McGraw-Hill Companies* 5th ed 1990: 76-79
8. Van der Linden F. Aspects theoriques et pratiques de l'encombrement de la denture humaine. *Revue d'Orthopedie Dento Faciale* 1975; **9:** 329-352

VDP survey

Sir,— I was interested, but not entirely surprised, at the findings of the survey of VDPs (having been a trainer and hearing their views) with regard to their career paths and view of the Health Service.

Firstly, that the reality of family dental practices, in ordinary towns across the country, does not reflect the 'ideal dentistry' presented to us all in dental school. The bulk of my patients want sound, basic dentistry via the National Health Service; which is both what they require and are able to afford. Dental schools seem to instil quite unrealistic expectations in their students. These views are developed in an environment where many feel that work done in NHS practice is second rate and consequently no good.

Secondly, that dental education seems to have achieved little in the way of instilling any sort of commitment to the rights of people (who pay for their education via taxes) in the community to receive NHS treatment. As professionals, do we not have responsibility to ensure that all can be treated, irrespective of their income? Vocational training, which in the main is funded by GDS monies, is perhaps the point where a more realistic picture of service provision can be provided. However, I suspect that little is done to provide a positive view of the bulk of the NHS dental treatment that they are providing. I would hope that all VDP course advisers were mainly committed to the NHS otherwise there would appear to be a conflict of interest with their funding. Further, this example sets the tone of the year for the VDPs along with any trainees who are working in practices where the trainer provides mainly private treatment. The negative attitude towards the NHS in this instance is reinforced on a daily basis.

I do not deny that the NHS dental service has many issues relating to funding that need to be addressed, but if we are to be respected as professionals, should we be enthused by a report which appears to present us as lacking in commitment to a comprehensive and affordable dental service? The consequences to many NHS practices are starting to be felt, as a fair proportion of dentists finishing VT seek positions with a high percentage of private work, wanting to provide 'flash' dentistry and turning away from traditional family practices. I hope this isn't the start of the profession losing track of what the public really wants.

D. Fairclough
Leigh, Lancashire

Implant treatment

Sir,— The authors of the survey reported in the British Dental Journal (*BDJ* 2001; **190**: 93-96) have attempted to justify their statement that 'psychoses' and 'psychiatric illness' are contra-indications to dental implant treatment (*BDJ* 2001; **190**: 465). They quote the Royal College of Surgeons guidelines that '(Implant) treatment is usually contra-indicated in subjects with psychoses/neuroses.' It may be argued that these statements and their defence are discriminatory.

In order to judge whether a patient with a psychiatric disorder would benefit or not from implant treatment it is imperative to obtain the opinion of an informed psychiatrist. A dental liaison psychatry clinic is an ideal venue for assessment. Using this approach we have many examples of patients with psychiatric illness for whom implant treatment has provided enormous benefits. The Royal College of Surgeons' guidelines should be re-considered.

R. G. Jagger and M. D. Enoch
Cardiff

The authors C. J. Butterworth, A. M. Baxter, M. J. Shaw and G.Bradnock from Birmingham Dental Hospital and School responds:
We thank Messers Jagger and Enoch for their continued interest in our recent paper.[1] Unfortunately many clinicians do not have the benefit of a dental liaison psychiatric clinic although we agree that patients with known psychiatric disorders should be fully assessed prior to embarking on any form of implant treatment. Indeed the results presented indicated that 80% of restorative consultants who were involved in implant treatment rated "psychoses" as a very important factor in selecting patients for this treatment modality. As such it forms a component of the overall assessment of the patient's suitability which is complex and multifactorial. In our experience, we have never excluded a patient purely on psychiatric grounds.

As we highlighted, the main problem in providing implant treatment within the NHS hospital dental service is one of inadequate funding and not potential discrimination against patients with psychiatric disease. The guidelines referred to are under the auspices of the Royal College of Surgeons and any comments regarding their amendment should be addressed to them.[2]

1. Butterworth C J, Baxter A M, Shaw M J, Bradnock G. The Provision of Dental Implants in the National Health Service Hospital Dental Services - A National Questionnaire. *BDJ* 2001; **190**: 93-96.
2. Guidelines for selecting appropriate patients to receive treatment with dental implants: Priorities for the NHS. Faculty of Dental Surgery, National Clinical Guidelines 1997, Royal College of Surgeons.

Please send your letters to:
The Editor
British Dental Journal
64 Wimpole Street
London
W1M 8AL