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Priority will be given to letters less than 500 words long. Authors must sign the letter, which may be edited for reasons of space

Minimal intervention

Sir,- We enjoyed reading the paper by Davenport *et al* (*BDJ* 2003, **195:** 87) and are prompted to write following the increasing publicity of the concepts of minimal intervention dentistry (MI) and the examination of the clinical needs of new dental students in Birmingham. The treatment needs of the students were generally low, but a significant number needed large restorations, mainly of occlusal cavities which needed restorative treatment well beyond the concept of MI.

So what is the relevance of all this? By definition minimal intervention with all the benefits of preservation of tooth tissue requires detection of disease at a very early stage and this implies more frequent and high quality examinations with the appropriate use of all the current optical radiographic and electronic aids now available to us. The paper mentioned above makes the point that we have no good evidence on which to base selection of a review interval and that we have no clear outcome measure of the value of any selected interval. The preservation of hard tooth tissue in a functional state seems a desirable endpoint as this is likely to reduce the amount of subsequent complex treatment.

Numerically our student group is likely to need a low number of restorations but the likely complexity of this small number of restorations implies a high cost to the community in the long term. As the most recent article reviewed in the paper is eight years old, treatment concepts have changed during this time, as the reviewer, Derek Richards, comments. It would seem therefore very ill advised to make changes to advice on review intervals based on the work available. Surely a large-scale trial using various review/ treatment/ preventive philosophies is long overdue. We must be very careful at present not to make changes based on a politically correct view that less reviews mean less dentistry in the long term or that prevention is an alternative to treatment.

Dental health is surely a combination of prevention and effective treatment done at the earliest stage possible to achieve the desired result. Although risk factors are as yet not fully understood we already know enough to tailor a review programme to risk groups in relation to most dental diseases and to feed this into a trial of review intervals. We hope this letter may stimulate debate on setting up such a trial which is at the very centre of our professional work and its development in the future.

R. F. Mosedale
F. J. T. Burke
Birmingham

The authors of the paper respond: *We concur with what appears to be the key issue raised in the letter which is the need for further high quality research on which to base recall intervals for routine dental checks. However, as pointed out in the conclusions of the paper, research of this nature is very difficult to conduct and must be underpinned by appropriate methodological approaches and incorporate clinical outcomes of relevance to professionals and patients.*

A point made by R. F. Mosedale and F. J. T. Burke is that treatment concepts have changed considerably since the date of the most recent paper in the review. However, a key challenge in assessing the effectiveness of dental checks is to clearly distinguish between the effectiveness of dental checks and that of treatment. Evaluation of existing literature in this field is hampered by a lack of consistent outcome measures.

The suggestion of 'the preservation of hard tooth tissue in a functional state' may represent such an outcome variable. However standard outcome measures agreed by the fields of dental caries, periodontal disease, soft tissue disease and orthodontics need to be developed and applied consistently in prospective research in order to facilitate comparison between different pieces of research in different settings. In addition the input of patients in the development of research questions and outcome measures has been neglected in the past and needs to be incorporated in any future research.

The point that no evidence does not justify less preventive dentistry is well made. I consider the review clearly states that there is no evidence either to support or to refute a policy of six monthly dental checks. The question 'what is an optimal dental recall interval?' does not as yet have an answer. Policy needs to be informed by either primary research comparing different recall intervals or the use of epidemiological evidence concerning risk factors and disease progression in order to base recall intervals on an individual's risk of oral disease.

C. Davenport, K. Elley
Birmingham
doi: 10.1038/sj.bdj.4811021

Whose waste?

Sir,- I recently received a bag from a refining company offering a good price for my 'waste crowns', and it prompted me to write a letter to share my views. Over nearly 30 years of practice I've always returned 'valuable waste' (i.e. gold crowns) to the patient in a pre-stamped addressed envelope via the refining company. They've always been grateful. Upon returning to the UK I had to ask a specialist for the removal of an entire failed 'roundhouse' bridge. After its removal, it was said to have been discarded as 'clinical waste'. Shouldn't we give the patient the choice of either having the value refunded (a third party prevents problems to the dentist) or perhaps a charitable donation (to a charity, not the dentist that is)?

S. Bray
Poole
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Financial balance

Sir,- Being familiar with the systems of remuneration practiced in North America especially Canada, I wish to support the concerns addressed by F. Dean (*BDJ* 2003, **195:** 422).

A capitation scheme guarantees a known cash flow and reduces much of the bureaucracy associated with the approval and collection of fees. However, it is a system in which patients with minimal

needs subsidise the costs of those requiring extensive care.

If this delicate financial balance is upset by an excessive supply of the latter either the dentist's income is reduced or the necessary treatment is not performed. Both outcomes are unacceptable.

Private dental insurance plans do provide patients freedom of choice regarding dentists, while liberating dentists to practise rational treatment which is financially acceptable to both parties.

Current technology permits prompt verification of the patients' insurance status and the payment of fees. It may also prevent or control the occasional overtreatment prescribed by less scrupulous colleagues.

In this era of change it would be unwise for the BDA and similar agencies to ignore the proven advantages of private dental insurance.

J. Hardie
N Ireland
doi: 10.1038/sj.bdj.4811023

Smoking cessation

Sir,- We read with interest Ms Stillman-Lowe's recent letter concerning hands-on training of dental personnel in one-to-one smoking cessation interventions with patients (*BDJ 2003*, **195:** 482). In 1995 we decided to tackle this issue within the dental hygiene diploma programme in Trinity College, Dublin. Two staff undertook training with the Irish Cancer Society and we were fortunate enough to be given appropriate teaching material by the National Institutes of Health in the USA. For several years the programme was delivered to second year dental hygiene students but it is now given in the second term of the first year.

Students spend six hours in lectures and workshops and are expected to complete a group project that is later presented before the school. We are now in discussion with the Irish Dental Hygienists Association to explore the possibility of a jointly run continuing education programme.

We believe firmly that dental hygienists are key personnel in the delivery of smoking cessation advice within the typical dental practice.[2] Dental hygienists focus on oral health and healthy lifestyles and are well trained in communicating health messages to groups and individuals. In addition, they frequently treat people with periodontal diseases and those with implant restorations.

Smoking cessation advice is as essential as oral hygiene advice for these individuals. Our experiences in training the dental hygiene students had led us to propose to the School of Dental Science that such training should be delivered to all dental undergraduates as part of oral health education.

K. Nylund
D. MacCarthy
B. McCartan
doi: 10.1038/sj.bdj.4811024

1. Helgason A R, Lund K E, Adolfson J, Axeisson S. Tobacco prevention in Swedish dental care. *Community Dent Oral Epidemiol* 2003; **31:** 378-85.

Sir,- We share the concern of C. Stillman-Lowe (*BDJ* 2003, **195:** 482) who drew attention to the dental team lacking the skills needed to encourage patients to quit smoking, but we believe a more fundamental problem prevents the pursuit of smoking cessation: motivation of dentists.

To put it bluntly, what is in it for the dentist? He/she will need to take time out from clinical work to discuss smoking. We believe such discussions have been discouraged by the NHS 'treadmill' because it has focused on clinical work at the expense of patient education. This belief is reinforced by the recent study by John *et al*[1] which showed that, compared to dentists in mixed and private practice, NHS dentists are less likely to record a patients smoking status and less likely to counsel them.

Furthermore, it appears that only a minority of dentists actually believe that the dental profession is effective in helping patients to stop smoking.[1] In fact dentists' scepticism is entirely consistent with a paper published recently which concluded that more rigorous research was needed to establish the efficacy of smoking cessation advice when delivered by dentists.[2] Smoking is the biggest cause of preventable death in the western world: it kills more than 120,000 in the UK every year. How can we refocus our profession to help prevent these deaths?

Two developments give primary care trusts (PCTs) the opportunity, and indeed responsibility, to address this problem. Firstly, the Health Development Agency has clearly stated that PCTs will take the lead in commissioning and providing smoking cessation services.[3]

Secondly, in April 2005, PCTs will take over control of the budget for general practice dentistry. What specific action should PCTs take? We suggest three things are needed:

- PCTs should use their smoking cessation staff to offer training to dentists and their team. This could be done with the section 63 postgraduate scheme and would alleviate the problem identified by C. Stillman-Lowe.
- PCTs should offer incentives to motivate dentists to spend time on smoking cessation. If they need inspiration, PCTs could look at the incentive schemes used to encourage doctors to give vaccinations.
- PCTs should promote research to establish the efficacy of smoking advice when delivered by the dental team.

This research should be conducted in field settings, so that dentists can see what can be achieved in field conditions.

By pursuing these three activities PCTs could equip and motivate dentists to play a major role in smoking cessation. We urge your readers who are involved with PCTs (and this may include many more of us by April 2005) to press for this action.

J. Woolgrove
K. Ma
London
doi: 10.1038/sj.bdj.4811025

1. John J H, Thomas D, Richards D. Smoking cessation interventions in the Oxford region: changes in dentists' attitudes and reported practices 1996-2001. *Br Dent J* 2003; **195:** 270-275.
2. Rikard-Bell G, Donnelly N, Ward J. Preventive dentistry: what do patients endorse and recall of smoking cessation advice by their dentists? *Br Dent J* 2003; **194:** 159-164.
3. Health Development Agency. *Cancer Prevention. A resource to support local action in delivering the NHS Cancer Plan.* London: Health Development Agency. 2002.

Sir,- Further to the recent smoking cessation-related letter (C. Stillman-Lowe, *BDJ* 2003, **195:** 482) regarding the lack of undergraduate/postgraduate training for dentists and hygienists in this area, until both the principles and practice of this topic are firmly embedded in the undergraduate curriculum, there will be a dearth of practitioners willing to undertake such work with enthusiasm.

However, in Scotland as recently as November last year, a 'Smoking Cessation' component was indeed delivered as part of a Section 63 oral cancer course. Here attendees – mostly dental graduates with more than ten years experience – participated with interest but felt the barriers of translating theory into practice related to a) lack of time and b) lack of remuneration. So what's new?![1]

V. Binnie
Glasgow
doi: 10.1038/sj.bdj.4811026

1. Chestnutt I G, Binnie V I. Smoking cessation counselling - a role for the dental team? *Br Dent J* 2003; **179:** 411-415.

Quality assessment

Sir,- Has the taste for 'quality' assessment gone too far? At Leeds, our undergraduate course has just received a GDC visitation; the University is also about to have an Institutional Audit by QAA (Quality Assurance Agency) which will include an

assessment of higher degrees in the new year. We receive Royal College visitations to assess our postgraduate course in orthodontics and the Specialist Registrars also undergo a record of in-training assessments (RITAs) which also involves some course and training review.

We are currently also having the same postgraduate course assessed by the University's in-house QMEU (Quality Management Enhancement Unit) to see that the course meets their specifications.

The University also undertakes regular course reviews. In addition of course, we have the RAE (Research Assessment Exercise) in 2006 but for which preparations are already underway – and there is going to be a 'mock' RAE ahead of 2006. Furthermore, of course I must keep up my own CPD and, as a clinical academic, I have always had appraisal but now have joint NHS and academic appraisal which also involves '360 degree feedback.' On top of that, we also have peer assessment for audit and lecturing skills and re-validation is looming. Do I have time to do my 'real' job? No! Certainly not as well as I would like or need to because of all the time it takes to do the necessary paperwork. Is that good? Only if you want good paperwork.

Please, if we agree that we still need (clinical) academics in preference to 'just' paper trails, then we must have time to do our job and the chance of progressing up the (increasingly unfeasible) career ladder. That is, if we also want excellent clinical graduates/postgraduates and excellent research. If that is so, please would these various bodies co-ordinate and find out about each others' activities so that some rationalisation can take place? Let's not just bolt on another layer of assessment – unless that is, we don't need (clinical) academics.

F. Luther
Leeds
doi: 10.1038/sj.bdj.4811029

Abusing the system?

Sir,- I read with undisguised amazement, the letter from Dr I. Storrar and most particularly the reply from your good self, concerning CPD (*BDJ 2003*, **195:** 230). It has been my premise from the inception of Continuing Professional Development (CPD) and Clinical Governance, that the whole is a baseless, expensive exercise engineered to satisfy the political correction that gushes from Whitehall and the upper echelons of the 'great and good' (sic) in our profession.

There have always been shysters in our profession, and I fear there always will be. These compulsory schemes have been instigated in an attempt to control the small minority of surgeons who pay no heed to conventional standards of ethical practice.

Your reply to Dr Storrar sums up most succinctly the naïve belief that you and your fellows hold, that CPD and Clinical Governance will rid us of the evil in our company. If you think for a split second that the shysters will do anything other than abuse the system in any of the legion of possible ways available to them, you are mistaken. Can I stress that; YOU ARE MISTAKEN.

The majority of us have been on lifetime learning since the day we graduated, with no coercion from on high. We find the whole business to be an insult to our integrity and a gross waste of precious NHS resources.

There are other ways of tackling the problem of the drill and fill for dosh brigade, and they don't involve hitting us all with the raft of nonsensical bureaucratic regulations to which you have given approval. I, and the majority of general practitioners, gave no such approval and will not do so in the future.

Of course this letter is much too honest and close to the truth for you to publish in the *BDJ*, but it makes me feel a deal better for voicing an opinion so diametrically opposed to that held by our 'political' masters.

M. Phillips
West Sussex

The editor responds: *I always feel that letter writers who end their letters with a challenge to the editor to publish because their comments are so critical do so as a ploy to ensure publication, but like many other editors I find myself falling for it every time.*

I would like to thank Dr Phillips for his comments, although I am not sure why he thinks that I am part of some conspiracy to foist unnecessary burdens upon his colleagues.

CPD is now a part of life for virtually all professions (dentistry was one of the last to embrace it) and demonstrates that we are serious about self-regulation.

I do appreciate that no system will ever control the people who commit fraud and carry out unethical practice, but for me that is not the main point, because I believe that CPD has much more potential for dentists who are obviously already engaged in learning, and it is in that spirit that the BDJ introduced the CPD pages. Whether Dr Phillips' letter is 'close to the truth' as he says or not I will leave for others to decide.

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