Letters

We welcome your letters on the content of *Evidence-based Dentistry* or issues related to the practice of evidence-based dentistry. Send your letters to ebdeditor@nature.com or Derek Richards, Editor, *Evidence-based Dentistry*, c/o Kim Black-Totham, Nature Publishing Group, Macmillan Building, 4 Crinan Street, London N1 9XW, UK.

Evidence-Based Dentistry (2007) 8, 27-28. doi:10.1038/sj.ebd.6400485

Dear Editor,

I write with reference to the editorial, "Screening" (*Evidence-based Dentistry* 2007; 8:2), and the article entitled *School dental screening does not increase dental attendance rates or reduce disease levels* (*EBD* 2007; 8:5–6). The results of a large randomised controlled trial of school dental screening have now been considered by the National Screening Committee (NSC) and a decision was taken in 2006 to recommend to the UK Chief Dental Officers that, *"..there is no evidence to support the continued population screening for dental disease among children aged 6–9 years."*[1]

On the basis of the NSC report, guidance provided by the Department of Health[2] suggests that, although a decision to screen school children for dental disease is a matter for individual primary care trusts (PCT), this school-based intervention should only be undertaken if there is evidence of its effectiveness in reducing levels of untreated dental disease.

This Department of Health guidance is helpful on three counts:

1. It clarifies that the aim of school dental screening is to reduce disease levels and is not designed as a vehicle to measure the dental health of populations, which is the role of epidemiology.
2. It recognises that school dental screening in children aged 6–9 years is ineffective at improving child dental health.
3. It requires PCT to demonstrate effectiveness before screening of children in other age groups is considered.

The screening of school children involves a complex interaction of different activities: first, a population of children at risk has to identified; the screening test must be applied; children screened as positive need to be seen by a dentist; and, finally, appropriate dental treatment has to be delivered.

The process of school dental screening may therefore be thought of as a series of linked operational interventions. When all the interventions that make up the screening programme are working effectively, then the programme will deliver the desired outcome, ie, reduced disease levels. When one or more of the steps is ineffective, then the quality of the programme degrades and its effectiveness becomes diminished.

The trial reported in *EBD* demonstrated that identification of the at-risk population and delivery of the screening test was straightforward. Failure of the process was associated with the post-test referral and treatment delivery steps. Should it be possible to ensure that screened positive children are first delivered to a dentist and, secondly, treated appropriately, then it is reasonable to assume that the effectiveness of the process would improve. Until evidence emerges to demonstrate that PCT are able to deliver the whole of the screening process effectively, there can be no place for the dental screening of children in the school setting. Offering any intervention for which there is no evidence of effectiveness is unethical.

The screening test itself, that is the decision to refer/ not refer an individual child following visual inspection of the teeth in school, is robust. Dentists are able to make a provisional positive 'diagnosis' reliably. This, however, is not a good enough reason to hijack screening in order to deliver other public health initiatives. Screening is a specific preventive intervention that is expected to lead to measurable reduced morbidity.

The Editor of *EBD* calls for greater clarity about the issues involved in school dental screening before we abandon it. We believe that the NSC has a clear understanding of the role of screening and, on the basis of the results of a well-constructed randomised controlled trial, has concluded that it offers little, either to the population being screened or those children who are screened positive. The challenge for the dental profession is now to leave behind a well-intentioned but fundamentally flawed public health intervention, and instead use the statutory access we enjoy to deliver effective preventive dental care in the school setting.

Keith Milsom
Halton NHS Primary Care Trust, UK

1. National Library for Health. National Screening Committee Policy. Dental Disease Screening (compiled by National Screening Committee); 2007.
2. Department of Health. Guidance: Dental Screening (Inspection) in Schools and Consent for Undertaking Screening and Epidemiological Surveys. London: The Stationery Office; 2007. Gateway Approval Reference No.7698.