Send your letters to the editor, British Dental Journal, 64 Wimpole Street, London W1G 8YS E-mail bdj@bda.org
Priority will be given to letters less than 500 words long. Authors must sign the letter, which may be edited for reasons of space.

Fear and anxiety

Sir, with reference to the paper *An audit of the UK national cancer referral guidelines for suspected oral mucosa malignancy* (*BDJ* 2006; **201:** 643-647), it must be recognised that patients have the right to read professional correspondence which relates to them and their condition.

The mention of the word 'cancer' causes fear and anxiety which are not helped by the fact that the statistics of the referrals show that most of the lesions are found not to be cancerous and that a patient may claim that they have undergone unnecessary worry and act accordingly.

It must also be recognised that the diagnosis has to be made by the professional to whom the patient was referred and this takes time.

The referring general dental practitioner must, therefore, be very careful to explain the need for referral to the patient in their own particular way so that the patient will not feel misled if the outcome is non-malignant.

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doi: 10.1038/bdj.2006.108

Dental patients in A&E

Sir, whilst working in several A&E departments as part of my postgraduate training in oral and maxillofacial surgery (OMFS), it struck me just how many patients with dental complaints present to the emergency department. The vast majority of this population are managed by the OMFS team.

Now I am medically qualified and working in A&E again, I am still amazed at the number of patients seen with dental problems. Most of them that I have seen are not registered with a dentist. Their management easily falls within the remit of a dental surgeon's capabilities, but poses a real challenge to doctors due to both their very limited training in all orofacial disease and trauma and the lack of appropriate materials and equipment in the emergency department setting.[1] This problem is compounded by the redistribution of OMFS service provision from a central 'hub' hospital which means many busy teaching and district general hospitals do not have an OMFS team on site. I would really like to encourage dentists to make contact with their local A&E departments with regards to providing contact numbers and full details of the dental services they can offer so patients are referred to local dental practices when seen in A&E with dental complaints. The literature states that less than two thirds of A&E senior house officers have knowledge of such details.[2] Until such a time when doctors are competent and confident in managing these patients, they need to see a dental surgeon.

This would be beneficial for doctors, dentists and most importantly, patients. Patients can be given appropriate information and sent directly to a dentist, avoiding the need for lengthy waits in A&E to be seen by a doctor who has little to offer or the onward referral to OMFS which may well involve transfer to another hospital.

S. Ifeacho
London

1. McCann P J *et al.* Training in oral disease, diagnosis and treatment for medical students and doctors in the United Kingdom. *Br J Oral Maxillofac Surg* 2005; **43:** 61-64.
2. Patel K K, Driscoll P. Dental knowledge of accident and emergency senior house officers. *Emerg Med J* 2002; **19:** 539-541.

doi: 10.1038/bdj.2006.109

Change the policy

Sir, long into retirement I had not realised that the UK Advisory Panel (UKAP) attitude to HIV infected Health Care Workers (HCWs) had not changed since the dark ages of 1990.[1] Whether or not to be tested for HIV was an issue for some HCWs in the late 1980s and early 1990s in view of the consequences of a positive result. Experience with medical, dental and nursing colleagues led me to believe that some colleagues would avoid a test.

As a result of my being at the forefront in the provision of care for people with HIV I had had the opportunity to gather opinions from a wide range of informed members of the healthcare professions in the UK and abroad. Review at that time of the literature regarding percutaneous injury, universal infection control procedures etc supported the opinion that the risk of transmission of HIV from a HCW was extremely unlikely, especially when working in a superficial body cavity such as the mouth.

In 1996 the *BMJ* invited me to contribute an editorial on 'The rights of HIV infected healthcare workers'.[2] In this I wrote *'A policy which supports healthcare workers is more likely to be effective than one which excludes and punishes them. Any policy that could reduce the number of healthcare workers wishing to be tested will result in a pool of undiagnosed and unsupported healthcare workers.'* The concluding sentences were *'The health professions need to use current knowledge to support those who become infected. In allaying public fears, the rights of healthcare workers have been subsumed for too long.'*

When this was published there was hope that attitudes within the professions and the UKAP (already in existence) might be influenced to remove this discrimination against HCWs. Ten years later evidence of the safety of dental procedures has continued to accumulate without any change in the policy of UKAP. It would be interesting to have a response from the UKAP as to why there has been no change in this policy.

P. Erridge
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1. Croser D. Written off. *Br Dent J* 2006; **201:** 497-499.
2. The rights of HIV infected healthcare workers. *Br Med J* 1996; **312:** 1625-1626.

doi: 10.1038/bdj.2006.107

Review the evidence

Sir, I want to congratulate you and David Croser for your editorial and article on dentists suffering from blood-borne infections, and specifically HIV (*BDJ* 2006; **201:** 485, 497-499). I was very involved in many of the dental HIV related issues of the 1990s, and while most of the policies developed then reflected the best available science at that time, much has been learned in the intervening years.

Virtually all of the currently available evidence indicates a much lower risk of HIV transmission in dentistry from providers to patients and from patients

to providers than we had feared immediately after the Dr David Acer case surfaced. There was a concern in those early years that we may be witnessing the 'tip of a yet to be recognised' mode of HIV transmission in dentistry and in health care in general. Numerous 'look back investigations or exercises' were conducted as well as improved surveillance activities to even better characterise the risks of HIV transmission in dentistry and all of healthcare. We now have the benefit of those many studies and can, with a high degree of certainty, describe those risks as being so low as to be virtually impossible to detect despite a much improved surveillance system.

It is rare for public health policy development to keep pace with rapidly advancing science. In the early 1990s those of us responsible for the protection of the public's health were by necessity required to develop policies based on incomplete and in some cases inadequate science. That is not the case today. Protection of the health of the public and healthcare providers is no small responsibility. I hope that in all areas, public health policies continue to reflect the best and most current science and are reviewed and modified when appropriate. Balancing of risks and the perception of risk is not easy but it is necessary. I agree that the time has come to review and revise those well intentioned policies of so long ago.

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doi: 10.1038/bdj.2006.110

An arcane policy

Sir, I am responding to *Written off* (*BDJ* 2006; **201:** 485) in my capacity as President of HIVdent. HIVdent is a not-for-profit web-based organisation located in the USA. It was established 10 years ago to collect and disseminate the latest evidenced-based research and information regarding HIV disease and oral health. The initial objective of HIVdent was to dispel fear through knowledge, in order to promote increased access to oral health care for people living with HIV disease, while positively impacting on healthcare policy decisions at the same time.

It was with tremendous disappointment and distress that I read that the UK's policy of eliminating clinical privileges for dentists who test HIV positive has not been updated to reflect today's advances in the medical management of HIV disease and dental infection control practices. Such an arcane policy does not represent the typically progressive nature of healthcare policy originating in the UK.

With the vast body of evidence accumulated since HIV/AIDS was first discovered, only one conclusion can be reached: it is time for UKAP to revisit and modernise their guidance to more accurately reflect today's epidemic.

D. A. Reznik
By email
doi: 10.1038/bdj.2006.111

Welcoming discussion

Sir, the executive of the Gay & Lesbian Association of Doctors and Dentists (GLADD) welcomed the editorial *Losing your livelihood* (*BDJ* 2006; **201:** 485) as we are aware of several members, dental and medical, who have faced significant hardship and stigmatisation after disclosing their HIV status. Our recent survey of organisations highlighted the lack of guidance and support mechanisms for HIV positive healthcare professionals. The Department of Health guidance (July 2005) explicitly states that organisations should make reasonable attempts to provide alternate employment avoiding exposure prone procedures, but this has not been implemented universally. The list of exposure prone procedures established by UKAP for dentistry remains substantial and as independent contractors dentists are especially vulnerable following diagnosis, with no real alternate career paths available.

We would support the calls of UKAP to review the evidence base again and we would call on the GDC and BDA to work together to provide a resource which advises HIV positive dentists on career options and the support available to them. The GLADD executive welcomes open discussion and informed debate about these issues which can affect any dentist, regardless of their sexual orientation.

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By email
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