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.

Interpretation services

Sir, while working as a general dental and maxillofacial SHO in large urban areas I have regularly encountered non-English speaking patients who require treatment. Obviously verbal communication is paramount in eliciting a history, making a diagnosis and ultimately treating someone. In the previous institution in which I worked a telephone interpretation service was available, as seems to be the case in most NHS hospitals. While being very useful, the service was inadequate for patients with detailed/complex complaints and histories. Also it involves much to-ing and fro-ing between patient and clinician on the telephone with only a non-medically informed interpreter as a link.

On one such occasion I was examining a Portuguese lady with a history of TMD/facial arthromyalgia. Treating such patients successfully can be a challenge at the best of times, but doing so via an interpreter it proved impossible to gather the relevant symptoms and information. On the advice of my consultant I reassured the patient as best I could and made arrangements for a further visit later. At this time we hoped to have an interpreter present in the room. Unfortunately we were informed by the hospital this wasn't the policy and the telephone service was all that was available. I am aware that some hospitals and trusts do provide in-house interpreters on request but this service is limited and certainly not available out of normal hours. I have on occasion had to rely on the interpreting services of other doctors who happen to speak the same language as a patient.

The follow up for the aforementioned patient proved just as frustrating with many things literally being lost in translation. Thereafter, I was shocked to hear that the NHS spends about £55 million pounds annually on translation services,[1] with £200 million spent by all departments annually on these. In the current climate of financial crises within the NHS and ongoing cutbacks, such a figure seems extraordinary. Surely this huge budget can be directed towards a more valid and user friendly system?

It is estimated that about 5.3% of the UK population speak another language at home,[2] while there are no official figures for the percentage of non-English speaking people in the UK. Everyone has a right to expect medical/dental treatment from the state but recent changes and events have shown us that the system is creaking under the weight of use. Obviously questions of identity and citizenship are involved here, but it seems that there is an element of people not fully integrated to the community as a result of a language barrier and who are potentially missing out on many public services. With regard to the NHS it is an added challenge to effectively treat such patients. There will always be a need for some interpreting services but the current level is excessive. Perhaps the Government should better fund and encourage English lessons for all non-English speakers as it would have far-reaching benefits for everyone.

P. J. Delaney
Liverpool

1. Easton M. Lost in translation. BBC, 12 Dec 2006.
2. Office for National Statistics. 2006.

DOI: 10.1038/bdj.2007.901

Inflexible exams

Sir, I write in response to the letter by B. Kayani (*BDJ* 2007; **202**: 707).

The plight of doctors in Asian countries is also similar. Doctors study here with sincerity and have good subject knowledge, but have to go through series of exams to prove themselves to practise in the UK. This takes years and costs thousands of pounds. The various exams cover the full range of knowledge and skills from a five year degree course meaning that candidates need to go back and revise literally everything. If a postgraduate dentist wants to practise, s/he also has to study the basics of biochemistry, microbiology, etc which s/he might have read ten years ago.

I also want to point out that the fees for such qualifying exams are so high that many Asians find them difficult to pay. The fees are equivalent to *lakhs* [hundreds of thousands] of rupees in any Asian currency. Furthermore, the qualifying exams are conducted only in the UK, so there are additional expenses for air fares, board and lodgings.

In my opinion the concerned authorities should reduce the difficulty level of these exams along with the fees. If possible exams should be conducted in other countries as well.

N. Bali
New Delhi

DOI: 10.1038/bdj.2007.902

Restoring faith

Sir, I am the local co-ordinator for the Chernobyl Children's Project (UK), which brings children affected by the Chernobyl disaster to England for four week recuperation holidays.

This year one of the children, Stas, who is 6-years-old and suffers from cerebral palsy, had a chronic toothache, had been unable to eat for some time and was clearly in need of urgent treatment. I telephoned a few local dentists who stated quite clearly and coldly that they were unable to help. NHS Direct helpfully gave me a list of dentists to call, of whom I contacted eight to be told that no-one could possibly help us. In desperation I booked a private appointment; I was told it would cost £50 for him to sit in the dentist's chair and any treatment would be extra but that he would not be able to be seen until the following afternoon. I knew our group would hold a coffee morning to raise the money needed for Stas to see the dentist but I was horrified that no-one seemed to care that we had a 6-year-old in excruciating pain and was shocked at the general attitude of all the dentists we had contacted.

Shortly afterwards I had a call from Mrs Dee Gorley of Thorpe Bay Broadway who had heard of our plight and was happy to keep her surgery open that night to see Stas. Despite a difficult treatment process due to Stas' medical and behavioural problems, one extraction and two hours later he was rolling

around the garden laughing and smiling in the sunshine, which was truly wonderful to see. He ate the most he has eaten since arriving in the UK and his mother was overjoyed.

We would like to thank Mrs Gorley from the bottom of our hearts for her compassion, kindness and empathy and for restoring our faith in human nature.

C. Rowson
By email

DOI: 10.1038/bdj.2007.903

Opinion based assessment

Sir, we are a group of full time academics, teaching and practising oral medicine at the dental school of the University of Milan. A few years ago we were discussing with students and colleagues the rate of adverse effects in performing oral biopsy, the gold standard for many conditions affecting the oral mucosa and jaws. Because of our evidence-based approach to clinical practice we searched the main databases extensively looking for answers based on sound research, but we were unable to find any. For this reason we planned a prospective study to investigate the frequency and characteristics of adverse effects following oral biopsy, including all consecutive procedures performed in our clinic. We presented the preliminary results during the 2000 meeting of the European Association of Oral Medicine, receiving good feedback from many colleagues who confirmed that it was a very good idea to fill in such a gap on a very common procedure. So we completed our study collecting data on nearly 300 consecutive oral biopsies, prepared a manuscript and submitted the article to a specialist journal, confident in a positive outcome. Although we were aware of the limitations of our study, we also knew that our data were at that time, and are still, the only evidence available on adverse effects following oral biopsy. Thus we were quite surprised when the paper was rejected, particularly because the first referee stated that '*There is no doubt that this paper is very well performed and presented. Yet I'm afraid that its merit is rather limited*' (and this was the whole referee's report) and the second that the '*study is too broad and superficial and not sufficiently focused*'. Without being discouraged by such a response we submitted the paper to another journal.

To keep it brief, the paper was rejected consecutively by ten journals, in some cases without being sent to the referees, and some other times on the sole basis of comments such as: '*it does not provide any new findings*'; '*that intraoral biopsy is a safe procedure with few complications, is obvious and self-evident*'; '*I do not see any new or relevant information*' and '*although the authors are quite thorough in their presentation, supplementing their text with inclusive and detailed tables, the paper does not provide any novel information*'. This indicated that not even a single referee made the effort to actually check on MEDLINE whether similar information was already available. The study design was never criticised. Notably editors of specialist dental journals suggested a '*journal aimed at the general practitioner*' while those of general dentistry recommended submitting it to a '*journal of oral pathology or oral surgery*'.

Eventually the paper was published,[1] but only by a journal whose Editor was one of us (A. Carrassi), and the full text is now freely available through PUBMED.

We all work as referees for a number of journals and we are aware of how difficult it may be to provide fair and evidence-based reviews, and it is not our intention to question a single referee report or editorial decision, however the story of this simple paper seems to suggest that a) opinion based assessment is not uncommon and can prevent pieces of evidence (although small and simple like this) from being available to clinicians and b) that to know the Editor of a journal is a trump in case of difficulties in publication.

G. Lodi, A. Sardella, F. Demarosi, A. Carrassi
Milan

1. Lodi G, Sardella A, Demarosi F, Carassi A *et al.* Oral biopsy. A prospective study on 286 consecutive procedures. *Minerva Stomatol* 2007; **56:** 241-251.

DOI: 10.1038/bdj.2007.904

SDEB update

Sir, the GDC Specialist Dental Education Board (SDEB) met for the first time in early July and I thought that this would be a good time to provide an update on our role and main areas of activity over the next year. The members of the group are Kevin O'Brien (Chair), Paul Cook, Peter Catchpole, Paul Wright, Liz Jones, and Brian Grieveson. The Chair and then the members were selected following an open recruitment process by the GDC. They were selected for their expertise and experience in specialist dental education; and importantly, they do not 'represent' any speciality, role or interest group in dentistry.

The SDEB was set up as part of the recommendations of the GDC Specialist List Review Group. The report and recommendation of the Group was produced by the GDC after extensive consultation with the profession. This report recommended that the SDEB should have the following remit:

- To develop a generic curricula framework, to be used by the educational bodies in developing curricula for individual specialties
- Approve individual curricula developed by the educational bodies of the Royal Colleges and the Universities
- Develop guidelines for approval of training programmes to be used by the Postgraduate Dental Deans
- Establish guidelines for the recognition of previous training, experience and qualifications towards the specialist training programme
- Develop a framework for the assessment of applications for equivalence of non-UK specialist training; to be used by the educational bodies in undertaking these assessments
- Approving equivalence assessment of non-standard applications for specialist listing
- Consider all other matters relating to specialist training and listing with the GDC.

While these are fairly confined aims, it could be easy for us to lose focus on the main objective that underpins our role. This is very simple – the role of the GDC, and hence the SDEB, is to protect the public. In other words we need to be certain that if a person is included on the GDC specialist lists the public can rest assured that the person has been adequately trained and has the competencies that a specialist requires. The guidelines for approval of the training programmes should include approval of the assessment of those competencies. I would like to emphasise that our role is not to re-open the discussion on the number or nature of specialist lists, nor, the training or conditions of service after the award of a Certificate of Completion of Specialist Training. The SDEB does not 'represent' dentists who are in training nor will we be a provider or assessor of specialist training.

Our main initial tasks are, therefore, to ask the educational providers to develop entry criteria for specialist training, along with curricula which will follow the generic curriculum documents that we will produce as well as the exit criteria necessary for completion of training. We also need to develop a workable system of quality assurance for the programmes that are provided. Other initial challenges are to develop systems that increase access to specialist training and to rationalise the many assessments that are currently being held at the end of training. The SDEB will act as an advisory body to

the Education Committee of the GDC.

Finally, there has been some initial confusion on our role. I am sure that this has resulted from delays in appointing the Board and uncertainty of our role on behalf of leaders in specialist training. We shall address this issue by ensuring that our section of the GDC's website is regularly updated, making regular contributions to GDC publications (such as the *Gazette*) and the dental press, in addition to presentations and personal contact with the relevant groups involved in specialist training.

I am very confident that our team will be up to this task and we will make great progress in the next six months, to enable us to set up a system that will protect the public and ensure that specialists are adequately trained and recognised. Further information can be found at http://www.gdc-uk.org/About+us/How+we+work/Specialist+Dental+Education+Board/.

K. O'Brien
By email
DOI: 10.1038/bdj.2007.905

Unjustified

Sir, in response to the letter by M. Lynch: *World's worst teeth* (*BDJ* 2007; **203:** 62), I beg to disagree with his/her statement that the Filipino population have the worst teeth in the world. Dr Lynch stated in the letter that s/he only travelled to the island of Mindoro and got the chance to treat the oral health problems of the Mangyans. The Mangyans are one of the remaining tribal groups in the Philippines and they only represent a very negligible percentage of the general Filipino population. Although the Filipinos were thankful for Dr Lynch's effort to improve the oral health of the village, s/he would have been wrong in generalising that Filipinos have the worst teeth in the world. Has Dr Lynch travelled to all parts of the Philippine archipelago or indeed to all parts of the world to justify this assertion?

R. Aguilar
Philippines
DOI: 10.1038/bdj.2007.906

The KITS scheme

Sir, in response to our article *The use of significant event analysis and personal development plans in developing CPD* (*BDJ* 2007; **203:** 43-47), some of your readers pointed out that the KITS scheme no longer exists. This is not strictly true. The functions of the Returning/Retraining Adviser (RRA) have in some deaneries been absorbed by other tutors/advisers or the deanery RRA has taken on additional roles.

So support to those needing it is still available from deaneries; however, the funding that was available has been devolved to SHAs as part of all dental monies. As it is a small amount, it is difficult to identify and SHAs will need some persuasion to release it for the purpose for which it was intended. Also the GDC stopped allowing the reduced amount for those on KITS.

So the funding for GDC registration, membership of the BDA and journal subscription, and subscription to a defence organisation, are clearly now more problematic. Attendance at Section 63 meetings is okay and RRAs continue to provide tailored support for individuals.

C. D. Franklin
By email
DOI: 10.1038/bdj.2007.907

Nurse registration

Sir, I write to offer my concerns about confidentiality breaches regarding dental nurse registration details.

When dental nurses are registered, they have the choice of recording their own home details or the practice details where they work against their registration number at the GDC. The website has open information of a nurse name and number. The personal details of the address which has been documented by the nurse – this is frequently their home – is then available to any member of the public who contacts the GDC by telephone or other means.

Clearly, the above arrangement is wide open to abuse and confidentiality breach. Not only do our registered nurses receive home mail from recruitment agencies with the intention of 'poaching' the staff we have trained and registered, but, my concern is that they are vulnerable to contact by undesirable personnel at their homes.

I would, at least, alert members to the above possibility of abuse, and suggest that the BDA consider approaching the GDC to change the system.

C. W. Crome
Surrey
DOI: 10.1038/bdj.2007.908

50 year reunion

Sir, I very much hope to arrange a 50th anniversary lunch or dinner for my fellow ex-students from the Royal Dental Hospital who started there in October 1957. They are invited to write to me in the near future at The Wellcome Centre for the History of Medicine at UCL, 183 Euston Road, London NW1 2BE.

Professor Stanley Gelbier
By email
DOI: 10.1038/bdj.2007.909