Letters to the Editor

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Priority will be given to letters less than 500 words long.
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THE SAME MISTAKES

Sir, opening further colleges and training more oral health care providers is the current practice to try and overcome the enormous and widening disparities in access to quality care within developing countries, especially in rural areas, but is it the correct course? In countries like Brazil and others, this practice has been disastrous with an insignificant improvement in oral health of the population and a growing dissatisfaction among those so trained due to few job opportunities leading to a search for other occupations, and also to closure of dental schools.

India is passing through the same stage and perpetrating the same mistakes. Fresh dental graduates are paid less then Rs 6,000 per month (approximately US$120), with many dental graduates forced to work in call centres or to change profession. Increasing the number of health professionals is not going to help the problem and will lead to tarnishing the profession.

Numerous dental colleges in India lack basic equipment and materials and are in such a bad condition that patients are being referred from them to dental clinics. Many such schools, admitting 100 students per year, have an out-patient department of less then two patients a day, but fake entries are added to the register to be shown at the time of college inspection. The students are being sold the degree, examination results are being manipulated and students who have never attended the college are being awarded degrees. The message is clear, 'pay the fees and get the degree'. The quality of dentists being produced in these schools is below satisfactory.

These schools have acute shortages of both teaching and non-teaching staff, with one BDS trained staff member running two or three departments and MDS staff are 'on paper' only, just for the inspections. College management recruit teaching staff of other colleges such as nursing or MBA, and non-teaching staff, to imitate doctors and patients. Many of them are caught red-handed but then nothing happens. There are many such schools running throughout the country.

The problem has gone much beyond the limits but can be dealt with if the dental council, government, and health professionals join hands. The dental council should hold regular inspections of the colleges and those lacking minimum standard criteria should be warned and if required, closed. Strict action should be taken against corrupt officers. Health professionals should not just be a witness to these acts. They should raise their voice in public even if the council is not willing to listen to such colleges. The government must understand its duty towards its people and act accordingly. No new dental colleges should be allowed to open for a period of a few years, and a minimum salary should be fixed for the graduate by the government. If the oral health of the community and the dignity of the dental profession are to be maintained then there are questions which we as health care professionals have to think about and answer.

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DOI: 10.1038/sj.bdj.2010.297

H_2O_2 AND THE LAW

Sir, I read with interest the article entitled *Clinical use of hydrogen peroxide in surgery and dentistry – why is there a safety issue?* by Patel, Kelleher and McGurk (*BDJ* 2010; **208**: 61-64). It is clear from the cases presented that dilute hydrogen peroxide solution is of very great value in the surgical management of head and neck oncology where complications can be grave indeed.

However, I did notice an incorrect statement in relation to the UK law in respect of the sale and supply of solutions containing >0.1% hydrogen peroxide. The current version of the Cosmetic Products (Safety) Regulations (CPSR)[1] restricts the concentration of hydrogen peroxide present or released by *'oral hygiene products'* to a maximum of 0.1%. Skin-care preparations may contain or release up to 4% and hair-care preparations up to 12% hydrogen peroxide. Unfortunately, following the House of Lords judgement in *Optident Limited and Another v. Secretary of State For Trade and Industry and Another*,[2] it is clear that products for tooth whitening are classed as cosmetics within the meaning of the EU Cosmetics Directive[3] (and thus the UK conformative legislation), and hence subject to the 0.1% maximum hydrogen peroxide limit.

The definition of 'supply' in the context of in-surgery tooth whitening does not yet appear to have been tested in the UK courts. Whatever arguments may be advanced in this respect, it does seem clear that providing a patient with a tooth whitening product for home use would constitute 'supply', and therefore fall within the ambit of the CPSR.

Consumer safety law is concerned with protection of consumers in the widest possible sense. Although the point is well made in this article that dilute hydrogen peroxide is safe for use on delicate soft tissues, it does not necessarily follow that it is safe for consumers to have unsupervised access to significantly higher concentrations of