Letters to the Editor

Send your letters to the Editor, British Dental Journal, 64 Wimpole Street, London W1G 8YS
Email 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.

Readers may now comment on letters via the BDJ website (www.bdj.co.uk). A 'Readers' Comments' section appears at the end of the full text of each letter online.

DENTURE RECORD

Sir, a longstanding NHS patient came in for her annual check up recently. She was a little overdue as I last saw her 16 months ago. As she was settling into the chair, I asked how she was getting on with the upper partial chrome/cobalt I fitted on her last visit. Immediately she appeared a bit sheepish and we all know the symptoms: she has either never worn it or the dog has chewed it up!

On examination I was surprised to see a well fitting and highly retentive denture in place and as I removed it with some difficulty, I was struck with horror as I realised it had not been removed since I fitted it 16 months ago – the patient was apologetic.

This is a record for me after 34 years in practice but I know records are there to be broken so over to you, respected colleagues!

P. R. Williams
Lowestoft
DOI: 10.1038/sj.bdj.2011.914

PRIVATE MEDICAL NOTES

Sir, I have recently incorporated my practice and as such I had to reapply to the CQC as a provider and as a manager.

One of the sections asked me to tick yes or no to the request to allow permission for the CQC or any of its 'representatives' (whoever they might be) to access my private and confidential personal medical notes from my GP.

I told them I didn't want to give this permission as I felt it was a violation of my right to have this kept confidential, and I was told that if I didn't, I wouldn't be allowed to register and therefore practise legally.

So I am being forced to give away a right that pretty much everyone else in the country has on pain of having my livelihood of over 30 years taken away from me.

I was advised that I could take this to the European Court of Human Rights but that I was unlikely to be successful.

We as dentists have to protect patients' notes and confidential information and can only release these under very special circumstances, for instance for a serious police inquiry like a murder case.

The argument is that managers have to be medically and psychologically fit. But if the CQC suspected there to be an issue, application could be made then, and if any manager withheld this information inferences could be made.

Drivers also have to conform to certain levels of 'fitness' but I would imagine there would be an outcry if the DVLA had access to every licence holder's medical notes.

Are other colleagues aware of this – have they signed and thought 'oh well...'?

Can the BDA fight for our rights?

Can anyone advise what I should do?

D. Burton
Leatherhead
DOI: 10.1038/sj.bdj.2011.915

UNFORTUNATE COMMENTS

Sir, I read the article by Patel *et al.* (*BDJ* 2011; **211:** 133-137) with interest. As I am a non-UK EEA qualified dentist myself I would like to make the following points:

- Non-UK EEA dentists did take up NHS general dental services (to the benefit of the UK population) at a time when inadequate numbers of UK trained dentists were available. The immigration of these dentists has also saved the UK Government a considerable amount of expenditure on training at the expense of other European governments
- It is unfortunate that Table 4 did not also include a column covering the UK trained dentist population. What proportion of UK trained dentists did VT? What proportion has experience of working with the few CDTs that are registered and even how many have extensive experience of working with a dental therapist?
- Comments on understanding of regional accents and dialects are unfortunate, first because it is only introduced in the discussion without any reference to it in either the methods or results sections and secondly because this is a problem also suffered by UK nationals if they move to parts of the country with strong regional accents and dialects.

W. Leyssen
Sheffield
DOI: 10.1038/sj.bdj.2011.916

FORWARD TO HARMONISATION

Sir, we wish to comment both on the paper by Patel *et al.*[1] and the comment made in the accompanying editorial.[2] The article provides figures on the movement of dentists qualified in member states into the UK. Unfortunately the discussion contains much in the way of anecdotal evidence, which is unfortunate, and there are other influences that the paper only mentions in passing. We would like to highlight the activities of the Association of Dental Education in Europe (ADEE) which has updated the documentation of DentEd mentioned in the article including the highly cited 'profile and competencies'

and 'curriculum structure' documents.[2,3] Both updated documents were a result of intense European discussion not only from schools but dental associations and regulatory bodies. There was strong representation from the UK in this debate. Progress of the harmonisation of standards across Europe is occurring; the pace of change is difficult to measure but it is happening.

At a recent ADEE conference we received a keynote address[5] from Professor Lesleyanne Hawthorne, University of Melbourne, on 'The Looming War for Skills: Global Demand for Foreign-Qualified Health Professionals'. This highlighted that movement of health professionals is not just peculiar to dentistry and certainly not only a European problem. There is a global shortage of skilled professionals and it does ask the question who will be filling the void for dentists in Eastern Europe and the Indian subcontinent? How many UK dentists look towards other countries to work such as the USA, Australia and New Zealand or even Europe?

The current European professional qualifications directive for open movement of professionals is being updated and a green paper has been released.[6] ADEE has made representation to the EU commissioner who realises that the system of automatic recognition continues to offer an effective solution for the mobility of dentists. However, the preliminary report has highlighted the need for a minimum training duration and there is broad consensus that the duration of training is sufficient. There is debate for using European Credit Transfer System (ECTS) credits instead of years or hours to define the minimum training duration. An area where further discussion is required focuses on Annex V of the directive which covers dental training subjects. Dental professional organisations and competent authorities of several Member States favour an update of the list of dental training subjects in this annex. Several stakeholders favour the inclusion of a list of achievement of generic and subject related competences in the directive (output-based training). The EU commissioner is aware that the Council of European Dentists and ADEE have made suggestions for updating this annex, which will lead to uniformity of training.

ADEE has focused on three points of interest in the directive and these include modernisation of training requirements, continual professional development and language skills (in particular communication skills). We have forwarded our documentation to the Commission as a ready-made European framework to be used for the training of dentists.

Therefore in answer to the editorial, we refute that there has been political failure and that 'Someone should do something'. The documentation and instruments already exist and are a way forward to harmonisation of European training.

A. D. Walmsley
W. Harzer
Association for Dental Research in Europe

1. Patel R, Eaton K A, Garcia A, Rincon V, Brooks J. An investigation into the numbers of dentists from 19 European Economic Area (EEA) member states currently registered to work in the United Kingdom and key differences between the practise of dentistry in the UK and their member states of origin. *Br Dent J* 2011; **211:** 133-137.
2. Hancocks S. One in three of us. *Br Dent J* 2011; **211:** 99.
3. Cowpe J, Plasschaert A, Harzer W, Vinkka-Puhakka H, Walmsley A D. Profile and competences for the graduating European dentist - update 2009. *Eur J Dent Educ* 2010; **14:** 193-202.
4. Manogue M, McLoughlin J, Christersson C *et al.* Curriculum structure, content, learning and assessment in European undergraduate dental education - update 2010. *Eur J Dent Educ* 2011; **15:** 133-141.
5. Hawthorne L. The looming war for skills: global demand for foreign-qualified health professionals. Keynote address ADEE annual conference, Helsinki, 2009. http://www.videonet.fi/toebd/adee2009/la/2/index.html (accessed August 2011).
6. Public consultation: Green Paper on Modernising the Professional Qualifications Directive. http://www.epha.org/a/4639 (accessed August 2011.)

DOI: 10.1038/sj.bdj.2011.917

PROPORTIONAL TO THE INVESTMENT

Sir, I write in response to the letter of A. Smith (*Askew advice*; *BDJ* 2011; **211:** 305) regarding the advice statement[1] from the Scottish Health Technologies Group (SHTG) on benchtop steam sterilisers, and the BDA's response to this.[2]

Readers will be aware that the decontamination of dental handpieces has been a contentious issue for many years. As part of its ongoing review of decontamination requirements, the Scottish Government's Dental Decontamination Group requested SHTG to provide advice on the use of vacuum sterilisers. The Decontamination Group is chaired by the Chief Dental Officer for Scotland and its membership includes Professor Smith and BDA representatives. The Group, as a whole, accepted the conclusions of SHTG.

It is also important to remember that the SHTG advice statement changed nothing; it did not impose any additional requirement on dental practices in Scotland, nor did it alter the current position that downward displacement (non-vacuum) sterilisers are acceptable in primary care dental settings. This is consistent with existing practice in England, Wales and Northern Ireland, where the government health departments recognise the uncertainty of current decontamination techniques consistently achieving dental handpiece sterility. Consequently, the use of vacuum sterilisers in primary care dental practices is not required by any government health department in the UK.

Regarding the BDA's comment on the SHTG statement, I can see no problem in welcoming an approach as 'common sense' where it is based on the principle that if there is insufficient evidence for a change in practice, limited resources should not be wasted imposing one. As with other issues in healthcare, only when the evidence base has been established can we then consider whether the health benefits likely to be gained are proportional to the investment they will require.

R. Kinloch
Chair, Scottish Dental Practice Committee, BDA

1. Scottish Health Technology Group. Benchtop steam sterilisers in primary care. Advice statement 003/11. http://www.healthcareimprovementscotland.org/programmes/clinical__cost_effectiveness/shtg/advice_statements/advices/advice_statement_003-11.aspx.
2. BDA Press Release. *BDA applauds commonsense approach to decontamination in Scotland.* http://scotland.bda.org/news-centre/press-releases/31407-bda-applauds-commonsense-approach-to-decontamination-in-scotland.aspx.

DOI: 10.1038/sj.bdj.2011.918

CULTURAL PREPARATIONS

Sir, the article *Investigation into the numbers of dentists from 19 EEA member states...* (*BDJ* 2011; **211:** 133-137)