# 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.

## PHARMACEUTICALS

### Animal ingredients

Sir, it has recently come to our attention that the capsules used in certain antibiotics (and also analgesics in capsule form) contain gelatine of animal origin. Details of capsule constituents is given in the patient information leaflet supplied with the medicine, but generally states simply 'gelatin'. This gelatine is generally derived from mixed porcine/bovine sources, and as such may be unacceptable to some patients for religious or ethical reasons. Whilst some of these patients would be happy to take these antibiotics as a necessary medical treatment, others may choose not to do so – especially if an alternative is available. Note: this consideration is not present in tablet form antibiotics eg metronidazole, co-amoxiclav.

At least one brand of amoxicillin (Accord) supplies capsules of bovine-only, Halal-certified origin, but obtaining these specific antibiotics may be difficult or impossible. Obviously this still does not solve the problem for patients wishing to avoid products of bovine origin. NEWT guidelines (for administration of medication to patients with enteral feeding tubes or swallowing difficulties)[1] do not specify whether amoxicillin capsules can be opened and their contents dispersed, so this is perhaps inadvisable.

A feasible alternative to amoxicillin capsules is to prescribe suspension form. Amoxicillin is available in up to 250 mg/5 ml suspension: a 100 ml bottle costs £1.33, compared to £1.30 for 21 × 250 mg capsules, or £1.57 for 21 × 500 mg capsules.[2]

Clindamycin capsules can be opened, but the NEWT guidelines suggest that the contents be dispersed in 'grape juice or maple syrup' due to the bad taste! Whether or not the patient would be happy to ingest contents which have been in contact with the gelatine-containing capsule should be discussed with them prior to prescription in these instances. Clindamycin is available in suspension in unlicensed form, so clinicians would likely need to discuss with the pharmacist whether dispensing this is possible. Clindamycin is therefore unlikely to be the antibiotic of choice in patients objecting to taking gelatine-based capsules.

As clinicians, we must inform our patients as to any risks of treatment that they may perceive as significant, and for many people, this may well include ingestion of porcine or bovine products. Patients should be fully informed about treatments and their alternatives; together with risks of declining treatment, in order to make an informed decision about their care. Clinicians may need to consider this when prescribing capsule-based medicines to their patients.

**H. P. Beddis, Leeds**


1. NEWT guidelines for administration of medication to patients with enteral feeding tubes or swallowing difficulties. Wrexham Maelor Hospital Pharmacy Department. Available at: www.newtguidelines.com.
2. British National Formulary. London: BMJ Group and Pharmaceutical Press. Available at: www.evidence.nhs.uk/formulary/bnf/current/5-infections/51-antibacterial-drugs/511-penicillins/5113-broad-spectrum-penicillins/amoxicillin.


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## CONTRACT DISPUTE

### Crass and insensitive

Sir, I write in response to L. J. Brinton's request for the personal experiences of striking juniors in the junior doctors'/dentists' contract dispute (*BDJ* 2016; **220**; 323–324). The BDA, in offering its junior hospital members the opportunity to take part in industrial action, has not only acknowledged that the contract is unfair but has allowed us to show our support with the BMA and our medical colleagues. A unity rarely seen in dentistry.

To celebrate strike action in similar format to the heartfelt voluntary efforts of Mr Sheikh and his colleagues[1] would be crass and insensitive. Indeed, no junior has taken the decision to participate in strike action lightly. I know I did not, it was the subject of much soul-searching but my patients were all very understanding.

Whilst short-term patient care may be affected by the strikes, it is my opinion that imposition of the new contract will adversely affect patient care by stretching an already stretched five-day elective NHS service to seven days without any additional staffing or funding. I feel it will also change the structure of the hospital profession overall, not only by normalising weekend hours, but it may act as a deterrent for those who are not able to work full time through maternity leave, parenthood or disability (the recently published equality impact statement openly admitting that women are more likely to be disadvantaged but is a 'proportionate means to a legitimate aim').[2] The future of the NHS should be for long-term patient benefit, not short-term political goals.

Whilst I will soon be completing my training and will spend very little time under a new contract (if at all), I wish to ensure that the junior dentists that follow me have been represented by us, their predecessors, to the best of our ability to ensure a safe and fair contract for all. To use the BMA's tagline, it's everyone's fight. We are one profession. We stand together.

**K. L. McDermott ('Junior Dentist'), Leeds**


1. Sheikh S, Khalid O, Bashir Y. Personal Account: A drop of dentistry in the jungle. *Br Dent J* 2016; 220: 160-163.
2. Department of Health. Equality analysis on the new contract for doctors and dentists in training in the NHS. 2016. Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/512696/jd-eia.pdf (accessed 12 April 2016).


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## REGULATION

### Amused and frustrated

Sir, I was both amused and frustrated by an advert that appeared in the 25 March edition of the *BDJ* (vol. 220 issue 6). It was placed on behalf of the GDC which is seeking to recruit clinical case examiners and includes the following sentence: 'You will work efficiently and manage a large and varied workload, bringing high levels of *accuracy and attention to detail*' [my italics]. Further on in the advert the following appears: 'We regulate across the whole dental team – dentists, hygienists,



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nurses, orthodontists and technicians'.

It is rather ironic that the GDC expects its case examiners to be accurate and pay attention to detail but appears not to place the same expectation on those who place advertisements on its behalf.

**C. Freeman, Sheffield**

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## ERRATUM

### Piecing the jigsaw

The above letter, published on 13 May 2016 (**220:** 429) only mentioned one author. The authors of the letter were: María Mercedes Suárez-Cunqueiro and Inmaculada Tomás, both of the Department of Stomatology, School of Medicine and Dentistry, Universidade de Santiago de Compostela, Spain. We apologise to the authors for this error and the inconvenience caused.

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## DENTAL EDUCATION

### Do we really have too many graduates?

Sir, we refer to the letter (*BDJ* 2016; **220:** 219) regarding the increase in the number of dental graduates in India. We believe this is not high in absolute numbers as per the population of our country; rather the distribution of dental graduates is relatively uneven. The question is, are we able to meet the WHO Standards of dentist: population ratio?

According to the WHO, the dentist-population ratio should be 1:7,500. Although the ratio in India is 1:10,000 (which is true only for the urban population) the reality is that more than 70% of the population of India resides in villages, where the ratio is 1:2,500,000.[1] Hence, almost three-quarters of the total number of dentists are clustered in the urban areas, which house only one-quarter of the country's population.

Dental graduates passing every year are not able to contribute to improving the oral health status of the country. The reason behind this saturation is the mushrooming of private clinics in selected areas only and the lack of job opportunities in the public sector. Only 5% of dentists are working in the government sector.[2]

Health services in rural areas are administered through primary health centres (PHCs) which each meet the needs of 20-30,000 people. However, there are no set criteria for posting a dentist at the PHC level in rural areas, thus not even 20% of the existing PHCs have the services of a dentist available for the population.[3] The irony is that the rural population do not have a dentist while dentists do not have jobs. The major missing link causing this situation is the absence of a primary healthcare approach in dentistry. Another contributing factor is that out of the total budget, the amount that is dedicated to health expenditure is very meagre, and out of this amount only a minute percentage is allocated for oral health-related activities. In fact, there is no specific separate allocation for oral health in the Indian budget.[4]

Consequently, the government should revise the public health sector regulations in relation to human resources as well as budget. Dentists must be appointed at the PHC and CHC level all over India. Short-term junior and senior residences should be made available in all the Central and State Government hospitals and the number of public sector jobs for dental surgeons and government dental colleges must be increased.

**R. Yadav, R. Rai, India**


1. Kothia N R, Bommireddy V S, Devaki T *et al.* Assessment of the status of national oral health policy in India. *Int J Health Policy Manag* 2015; **4:** 575–581.
2. Jain H, Agarwal A. Current scenario and crisis facing dental college graduates in India. *J Clin Diagn Res* 2012; **6:** 1–4.
3. Tandon S. Challenges to the oral health workforce in India. *J Dent Educ* 2004; **68:** 28–33.
4. Ahuja N K, Parmar R. Demographics and current scenario with respect to dentists, dental institutions and dental practices in India. *Indian J Dent Sci* 2011**; 3:** 8–11.


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## ORTHODONTICS

### Monopolistic behaviours

Sir, I object in the strongest possible terms to N. Stanford's false and misleading claims in the *BDJ* which are without proper foundation and not only unprofessional, but likely illegal too.[1,2] His comments go far beyond just a difference of clinical opinion, especially when he states and implies that FastBraces claims have been found by any 'body' to be misleading; this is entirely false. FastBraces claims follow evidence-based medicine[3] best practice, and the results in the hands of GDPs and patient satisfaction for the most common orthodontic cases speak for themselves over many years. I believe that N. Stanford owes myself, Fastbraces and the *BDJ* readership a full and unreserved apology, at the very least. Protectionism and monopolistic behaviours are bad for our profession and patients.

**T. Kilcoyne, UK Advisor for FastBraces**


1. Stanford N. Orthodontics: Fast removal of claims. *Br Dent J* 2016; **220:** 220.
2. Kilcoyne T. Orthodontics: Not so Fast. *Br Dent J* 2016; **220:** 430.
3. Greenhalgh T, Howick J, Maskrey N, Evidence Based Medicine Renaissance Group. Evidence based medicine: a movement in crisis? *BMJ* 2014; **348:** g3725.


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