General Dental Practitioners updated its online publication on the subject[2] which is freely accessible via the Open Standards page on the FGDP website www.fgdp.org.uk.

Unfortunately, this recommended dose increase has come too late to be included in BNF 72 (available in September 2016 and to be distributed throughout the health service including to dentists with NHS contracts) and BNFC 2016/17 (published August 2016).[3] However, the change may appear online between now and publication of the next paper issue of the BNF in March 2017.

Dentists will also be aware that in 2014 the dose of amoxicillin for oral infections was increased to 500 mg three times a day for up to five days, with review at three days, for all adults and children aged over 5 years old. This dose recommendation has been included in the BNF since September 2014 (BNF 68).

It is essential that dentists are aware of antibiotic dose changes and prescribe in accordance with recognised guidelines to help limit further antibiotic resistance.

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1. Public Health England. Management of infection guidance for primary care for consultation and local adaptation. May 2016. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/524984/Management_of_infection_guidance_for_primary_care_for_consultation_and_local_adaptation.pdf (accessed July 2016).
2. Faculty of General Dental Practitioners (UK). Antimicrobial prescribing for general dental practitioners. 2014, updated June 2016. Available at: http://www.fgdp.org.uk/publications/antimicrobial-prescribing-standards/acute-dento-alveolar-infections.ashx (accessed July 2016)
3. BNF Editor, Personal communication, July 2016.

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OMFS

Gender imbalance?

Sir, I am a female undergraduate and was recently allocated a two week placement in a combined oral surgery and maxillofacial department in a leading hospital in the UK. This has strengthened my understanding of the importance of quick referral for sinister appearing lesions, my ability to closely follow patients' hospital attendances both pre- and post-operative, and the impact trauma and malignancy can have on not just a patient's quality of life but also that of their family.

I respect and admire those in the maxfac speciality, having the patience to complete the long pathway, the intense hours and the retention of immense detail of head and neck anatomy. However, I have not encountered one female maxillofacial consultant and was very disappointed to learn, following further enquiry into the dynamics of the team, that the entire team of maxfac consultants were all male. This posed a serious question: where was the female representation? Undoubtedly women are just as capable as men, so why was there a serious lack of female consultants?

I am therefore writing in the hope that a female maxfac will get in touch and shine some light on the matter. I have gathered that motherhood and this aspiring career do not mix well. However, I believe there must be females out there who have a good balance of motherhood and a maxfac job. I feel that increasing awareness to all dental undergraduates of real life stories of those with families and careers is very important as we are the next generation in this profession. It can become all too easy for women to see the lack of a gender balance in this speciality and then decide it is not for them. I wouldn't be surprised if many did want to pursue this career but believe they'd need to sacrifice motherhood in order to do so – which surely can't be right? Any advice from female consultants out there would be appreciated!

A. Ahmed, Leeds

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An inspiring specialty

Sir, how refreshing to read of a dental core trainee wishing to take up a career in oral and maxillofacial surgery (*A dentist's life*, Vol. 221 pages 54–56) – I too was galvanised by experiences as a specialist trainee in those very same hospitals.

Two observations were the foundations of my research career in the specialty: 'We always see more assault patients in a miners' strike' and 'people with fractures often came from a few licensed premises'. Consequently, the circumstances of maxillofacial trauma and the potential for preventing it became the subject of my PhD, which with my Cardiff team's subsequent research, showed that violence which puts people in hospital is very powerfully associated with unemployment and deprivation.[1] We also found that the police rarely knew about violence in licensed premises and that the use of the unique information available from trauma patients about where, when and how they were injured could cut violence and its huge costs substantially.[2,3] It also became clear from our trials of motivational interviewing that brief advice about alcohol was effective when given to patients having sutures removed in maxillofacial clinics and in other settings.[4]

These and other discoveries were the basis for advocacy for prevention. In the mid-1990s, our *Face of Wales* campaign resulted in a switch initially to toughened and then polycarbonate glasses in pubs. The UK Government was persuaded to include health in its Crime and Disorder Act 1997 to mandate Community Safety Partnerships between the police, local authorities and other services. In 2008, the Home Office adopted information sharing by A&Es (the 'Cardiff Model') to tackle alcohol-related violence. In 2010 and 2016, successive UK governments applied this model to reduce all kinds of violence, supported by a new information standard (ISB 1594), and violence reduction nurses across England.

The delivery of effective alcohol advice was embedded in the NHS in Wales through our *Have a Word* programme; 16,000 professionals have now been trained and the programme adopted by Public Health England. *Have a Word* is helping to ensure that Dental Defence staff screen 140,000 armed forces personnel for alcohol misuse and advise accordingly.

Encouragingly, since the mid-1990s violence has been decreasing. In Cardiff's only A&E in 2002 we saw 80 patients/week who had been injured in violence. In 2016, there are around 30/week. In 2015, in England and Wales, there were 100,000 fewer violence-related A&E attendances than in 2010.[5]

My early feet-on-the-ground experiences also resulted, indirectly, in the Police Science Institute at Cardiff University – inspired by the dental school model, the College of Policing, which in turn was inspired by the Royal College model. A national 'What Works Centre' in crime prevention,inspired by the NICE model, was also established.

Go, dental core trainees!

J. Shepherd, Cardiff

1. Shepherd J P. Violent crime in Bristol: an accident and emergency department Perspective. *Br J Criminol* 1990; **30:** 289–305.
2. Florence C, Shepherd J P, Brennan I, Simon T. Effectiveness of anonymised information sharing and use in health service, police, and local government partnership for preventing violence related injury: experimental study and time series analysis. *BMJ* 2011; **342:** d3313.
3. Florence C, Shepherd J P, Brennan I, Simon T R. An economic evaluation of anonymised information sharing in a partnership between health services, police and local government for preventing violence-related injury. *Inj Prev* 2014; **20:** 108–114.
4. Smith A J, Hodgson R, Shepherd J P. A randomised controlled trial of a brief intervention after alcohol-related facial injury. *Addiction* 2003; **98:** 43–52.
5. Sivarajasingam V, Page N, Wells J et al. Trends in violence in England and Wales 2010-2014. *J Epidemiol Community Health* 2016; **70:** 616–621.

DOI: 10.1038/sj.bdj.2016.715