Please note that all letters must be typed. Priority will be given to those that are less than 500 words long. All authors must sign the letter, which may be shortened or edited for reasons of space or clarity. All letters received are acknowledged.

Developing competences

Sir, — The 'personal view' by Drs Cabot and Radford in the April 10 edition (*BDJ* 1999; **186:** 318-319) is both timely and appropriate. For some time now anecdotal reports of lack of experience of graduates have been circulating. I suspect the older generations always thinks they were better trained and educated than the new! The authors explore the changes in dental education but invite a debate on core competences. I write to help facilitate that debate, because both in the UK, through the Medical and Dental Education Network (MADEN) and in Europe through the Advisory Committee on Training of Dental Practitioners (ACTDP) progress has been made in defining and developing competences.

Many people will not be aware of the Advisory Committee and its role. Briefly, it is an official Committee of the European Union Commission, and its task is to ensure comparable standards of training of dental practitioners in the Union, both in practice and specialised fields. This ensures equivalence and freedom of movement. Each country appoints three 'experts'; one from the profession, one from university and one from the competent authority (in our case the GDC). Currently from the UK the members are myself, Professor Alan Brook and Professor Robin Basker. It meets once a year in plenary session and appoints a working party to do the work! In the early days the committee was instrumental in developing the Dental Directives, but on-going work has looked at post graduate education, vocational training and recently, and crucially, competences of a newly qualified graduate and the core knowledge and understanding to achieve these competences.

Over the years it has published reports that are advisory to the member countries and help the EU formulate policy within the Commission.

I would like to return to why the directives and now competences have been formulated. All persons are entitled to be assured that professionals practising in the EU possess the basic knowledge and skill essential for their patients' protection and safety. In developing the Dental Directives (76/687/EEC) a basic minimum list of requirements for dental education was established. Any country joining the EU has to conform to these directives. But they do not identify the level of competence of the individual dentist. To this end the ACTDP established a document (XV/83 16/8/93) which describes competences of a new graduate.

So what is the meaning of competence? The definition used in the ACTDP paper is 'a combination of skills, attitude and knowledge which provides the clinician with sufficient competence to undertake a specific clinical task'. It implies more than mere technical ability and adopts a holistic approach through a diversity of education. To achieve this level of competence requires a system that moves away from curriculum/hour-based education towards an outcome-based type. In essence, the graduate dentist should be competent to practise dentistry. In the UK we follow this with a period of vocational training with a view to converting that competence, with experience, to proficiency.

To further develop this theme papers are being developed by ACTDP on competences of a specialist and competences that a practising dentist should fulfil post basic training.

The authors have alerted us to the questions, I hope this letter indicates serious consideration is already happening in Europe.

W R Allen
Chairman of Council, BDA
London

High quality clinical studies

Sir, — We would like to congratulate the *BDJ* in its stance to improve the quality of the reporting of randomised clinical trials (*BDJ* 1999; **186:** 207). This is a vital step in promoting evidence-based practice and we hope that other dental journals follow suit.

Evidence-based dentistry as a concept is hard to fault. Who could disagree that our treatment decisions should be based on scientifically proven principles and practice? Unfortunately, the quantity of evidence is enormous but the robustness and quality of that evidence variable, therefore making the application of evidence-based practice difficult. More often than not our clinical judgement is based on 'expert' opinion rather than good clinical evidence.

Clinical practice requires robust clinical studies to highlight best practice, but from which studies? The first stage in the process is to investigate the available evidence by means of a tool such as the systematic review. This should show the available quality literature. In dentistry only a few Systematic Reviews have been completed[1,2,3] and at Cardiff we are in the process of completing another, entitled 'The longevity of routine dental restorations'. It is obvious from our work that the standard of reporting of randomised controlled and other clinical trials falls below the standards discussed in your leader on March 12 1999. Where there is a lack of sufficient information the results from such studies are substantially less valuable and may in some instances be misleading.

Therefore, we congratulate you again on your stance, which is vital if we are to practice to the highest level, through the use of high quality clinical studies.

B Chadwick, P M H Dummer, F Dunstan, A S M Gilmour, R Jones, C Phillips, J S Rees, S Richmond, J Stevens, E I Treasure
Cardiff

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Prescriptions from dental practitioners

Sir, — There are provisions under the Medicines Act (1968) to enable a practitioner to provide an emergency prescription for a patient, for example by fax direct to the pharmacist who can then dispense the prescription to the patient. The original prescription must then be sent to the pharmacist to enable him or her to comply with the law.

This is clearly a sensible arrangement as there are situations where it can be difficult or even impossible to give the patient the original prescription directly.

So far so good. However, the Medicines Act stipulates that the practitioner must be a medical practitioner whose name appears on the medical register. If you are dental practitioner the pharmacist is not allowed to dispense your prescription unless he or she has the original copy no matter what the circumstances are. The same will apply if you are an oral surgeon with a medical qualification but not on the medical register.

This has been on the statute since 1968 and there must be countless dentists and pharmacists who have broken the law unwittingly. Even had they telephoned the General Dental Council, as I did recently, accurate advice would not been available. It

took a call to the Pharmaceutical Society to obtain accurate information.

This situation is more than inconvenient, it is potentially dangerous for our patients, and it is demeaning for us as dental surgeons if we have to ask a medical practitioner to write our prescriptions for us. The Medicines Act needs to be changed.

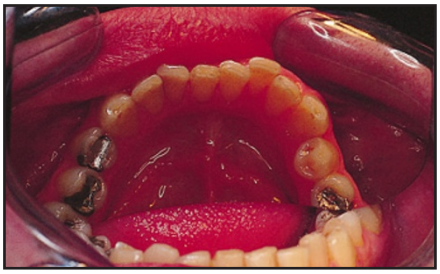
S Orlans
London

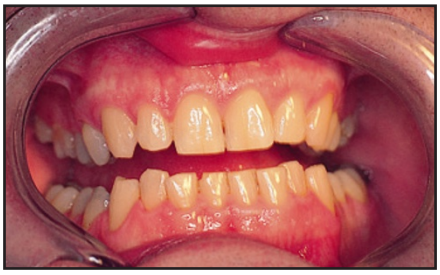
Supernumaries in the mandibular incisors

Sir, — I was interested to read the case study by Tanaka *et al* (*BDJ* 1998; **185:** 386-388) reporting the presence of supernumary teeth in the incisor region of the mandible. They commented that there was no case reported in the white population.

I enclose clinical photographs of a middle-aged, medically healthy, male patient who regularly attends our practice. He has fully erupted bilateral mandibular supernumaries as decribed in the Japanese case, but he is of a Caucasian racial group. The teeth are asymptomatic and there are no other supernumary teeth. Is this gentleman unique?

R Heathcote
Macclesfield





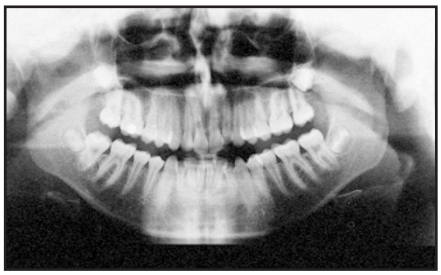
Caucasian evidence

Sir, — I was interested to read the paper by Tanaka *et al* about bilateral supernumerary mandibular incisors (*BDJ* 1998; **185:** 386-388).

The authors may be interested to know that I have a Caucasian male patient with the same condition.

He has just completed his orthodontic treatment which involved the extraction of the most distal incisor bilaterally.

S Elworthy
Cranbrook



Author, S Tanaka, responds: *Before this suggestion, I and my co-authors confirmed that bilateral supernumerary teeth in mandibular incisors were erupted not only in Japanese people but also in a Caucasian, as shown by correspondence received from Dr Sarah Elworthy from the Golding House Dental Practice, UK.*

Also, I am very surprised to see the interesting transparencies from R Heathcote in which bilateral supernumerary teeth are presented.

Oral health report

Sir, — The British Nutrition Foundation is a charitable body funded by 'the food industry, government and other sources' and aims to promote 'the nutritional well-being of society'. From time to time it appoints task forces to study current nutritional problems. The most recent report — 'Oral health: diet and other factors'[1] — was made by a task force set up several years ago, and among whom, naturally, were several eminent dentists. One of them, Professor Martin Downer, has described in the current issue of Community Dental Health[2] why, 'many members might have had second thoughts about joining the task force had they known beforehand the amount of toil, sweat and tears they were letting themselves in for'.

The reason appears to be that the task force included scientists involved with confectionery and soft drinks industries and BNF's aim was not foremost in their minds. Their 'primary desire was to ensure that the report contained no views that would be likely to have an adverse effect on the marketing of cariogenic products'.[2] Nevertheless, the advice in the Scientific Basis of Dental Health Education[3] was not 'undermined or compromised in the final report'. Our colleagues deserve the profession's best thanks.

The report is excellent and could surely serve as a standard text for years to come. It uses simple straightforward language and, particularly in the recommendations to individuals, avoids complexity. In one respect, however, the food industry faction won the day. The recommendation to Central Government that it should 'Consider strengthening legislation restricting the advertising, sale and consumption of tobacco and clarify legislation controlling the sale of cured chewing tobacco' (to which, hear, hear), was not preceded by one urging legislative control of the marketing of cariogenic foods and drinks, particularly for children.

If people consume cariogenic products without discretion (mostly, as Professor Downer points out, they do so in groups of the population which suffer multiple deprivation), an alternative to legislation is to 'inform their discretion'.[4] So why did the BNF not fulfil its aim of promoting the nutritional well-being of society '... through the impartial interpretation and effective dissemination of scientifically-based nutritional knowledge and advice'? The report, all 144 pages, costs £75.00 and even our own library has had to ask borrowers on this account to take special care when returning it by post. The chance that it will pop up in the local library or airport bookstall is slender.

I wonder, therefore, if the BNF can explain why such a unique and worthwhile report costs so much. In any case, would food industry supporters of the Foundation help it to honour its status as a charitable organisation by subsidies and enable the report to be published at, say, £7.50 per copy?

D W Sarll
High Wycombe

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London
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