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E-mail 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

Book review

Sir,- I was pleased to see the review of the new textbook *Essential Dental Public Health*¹ in *BDJ* 2003 **194**: 522 but very disappointed about what was said. This is a valuable addition to the texts available for teaching of dental public health (DPH) at undergraduate and MSc level.

In particular, it is the first text to bring together the key themes of the new modern DPH movement in an accessible form for undergraduate dental students. This is especially important, as DPH is now recognised as a core subject in the dental undergraduate programme as outlined in the GDC's *The First Five Years*². Quite rightly the review made these points clear. However, I would like to differ from the reviewer's (generally positive) views on the following points.

First, I am not sure it is any longer correct to state that dental public health can be regarded as a 'mainly postgraduate subject'. We should now regard it as we do the other dental specialties - that it is a core topic of the dental undergraduate programme, with postgraduate training opportunities for specialisation.

Second, the approach taken of raising discussion points is now a fairly widely adopted approach taken in texts aimed at both undergraduate and postgraduate levels. Some of these discussion points do not necessarily have 'right or wrong' answers. They are designed to help students take a questioning view of a topic, and perhaps to realise the complexity and uncertainty, which, unfortunately, is the actual state of the world. In many ways this is a potential strength of the book, particularly if the related website www.oup.co.uk/isbn/0-19-262974-3 becomes a lively and dynamic forum for discussion.

Finally, the reviewer states that 'because several of the authors are from London dental schools... there is a resultant significant emphasis on a whole-population approach to public health', and effectively criticises the book for making strong arguments for this approach. This is an unfair criticism as, firstly, the

impression given is that this approach is solely advocated by authors from London dental schools, and so does not explain why WHO³ also advocates the whole population approach to public health and health promotion.

Also the book describes the whole population approach, the related targeted population approach and the 'high risk' approach and discusses the advantages and disadvantages of these objectively and neutrally and goes on to describe the value of combinations of these strategies for tackling oral health problems. Perhaps this topic could be the first for discussion and debate on the website, which has yet to go live.

Although anecdotal, feedback from students in Bristol to the book has been positive. Personally, I would wholeheartedly recommend the book to all dental undergraduates, and those post-qualification dentists (specialising or not) who feel the need for an introduction to dental public health. This may include a large number of dentists, as Alan Milburn wanted us all to be dental public health practitioners.

A. Sprod
Bristol
doi: 10.1038/sj.bdj.4810450

1. Daly B, Watt R, Batchelor P, Treasure E. *Essential Dental Public Health*. Oxford: Oxford University Press, 2002.
2. General Dental Council. *The First Five Years: A Framework for Undergraduate Dental Education*. General Dental Council, editor. 2nd Edition. 2002. London, General Dental Council.
3. WHO. *Ottawa Charter for Health Promotion*. WHO, editor. 1986, Geneva, WHO

Clinical audit

Sir,- Today I received a letter from the Dental Practice Board reminding me that I will be in breach of my terms of service if I have not undertaken 15 hours of peer review and clinical audit by the 31st March 2004.

With seven other dentists I completed a collaborative clinical audit in January this year and submitted it to our local LAPRAP at North Stoke Primary Care Trust. In April it was approved and passed to the

NCCPED for payment. To date, we still have not received payment. I telephoned the DoH who informed me that the NCCPED had been 'wound up', and no information could be given on who to contact for further information.

Coincidentally, I rang the BDA for advice, and a helpful new employee told me that he had just moved to the BDA from the CVT, who shared offices with NCCPED, and NCCPED's staff have just been cut from 5 to 1. This seems odd, when linked to the fact that the deadline is approaching for the first wave of the audit cycle.

Through your pages I would like to warn dentists about to embark on clinical audit or peer review that the payment system appears to have been dismantled. As our 'trade union', I would also be grateful if the BDA could remind the DoH and Dental Practice Board of their own terms of service, and possibly negotiate interest payments on late payment.

All that aside, the audit was a very enjoyable and informative process. It is a shame that it does not appear to be supported by the DoH. Furthermore I suspect this is an omen of the shambles that will ensue following the implementation of the Health and Social Care bill.

P. Thornley
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doi: 10.1038/sj.bdj.4810451

Orthodontics issue

Sir,- When one sees the names of authors incorrectly spelt in a cited paper one has the uncomfortable feeling that those referring to it may not be completely familiar with the original text.

Be that as it may I would like to put the reference to Stevens (sic), Orton and Usiskin¹ quoted by Ide and Scanlon in their research paper *The role of professionals complementary to dentistry in orthodontic practice as seen by UK orthodontics* (*BDJ* 2003, **194**: 677) in context. At that time, now almost 20 years ago, it is true that we concluded in our paper that a reduction in the number of

UK orthodontic trainees might be prudent. However we also stressed that this suggestion was made having applied certain assumptions to our mathematical model.

These were clearly stated in the text as being firstly that general dental practitioners (defined as those treating less than 100 orthodontic cases per year) would continue to treat the same number of orthodontic patients.

Secondly the growth rate for the number of courses of orthodontic treatment carried out in the GDS would be a maximum of one per cent per year. Lastly, because it seemed unlikely that significant 'new money' would be found to support further growth in GDS orthodontic treatment, there would not be a significant increase in the average unit cost of orthodontic treatment and thus the amount of fixed appliance treatment being undertaken within the GDS.

In fact none of these assumptions proved to be correct. First, the amount of GDS orthodontic treatment undertaken by the GDP since then has declined steeply. Secondly the proportion of orthodontic treatment undertaken with fixed appliances has more than doubled resulting in a remarkable growth in expenditure for GDS orthodontics which has now reached 10 per cent per year. The findings of our paper are thus largely irrelevant to Ide and Scanlon's consideration of the contemporary role of orthodontic PCDs in the UK. Much more appropriate would have been to cite Chapter 6 of the Standing Dental Advisory Committee's 1992 report on orthodontics². Sadly, because of its implications at a time when sensitive discussions about NHS dental remuneration were going on, this excellent and far-sighted report was never published.

Among its many recommendations (most of which have since come to pass!) was an estimate that for the UK to enjoy the same high standards of orthodontic care as those which pertained in Scandinavia at that time, we would need 1300 orthodontic specialists supported by orthodontic therapists. It would seem that 10 years on and with just over 1000 orthodontists on the UK specialist register this estimate was not far out. All we need now are the orthodontic therapists.

C. D. Stephens
Bristol

doi: 10.1038/sj.bdj.4810452

1. Stephens CD, Orton HQ, Usiskin LA. *Future manpower requirements for orthodontics undertaken in the general dental service*. *Br J Orthod*, 1985; 12: 168-175.
2. Report of an expert working group on orthodontics in the National Health Service. Received by the Standing Dental Advisory Committee 5th February 1993.

One of the authors of the paper, Mark Ide, responds:

I should like to thank Professor Stephens for his letter regarding our paper and can only apologise for the misspelling of his name. We wrote this paper before changing over to regular use of citation manager software and did not pick up the error in various checks. The statement regarding his paper was primarily present to ensure that we had what appeared to be a balanced summary of literature involving as many UK workers as possible.

This clarification of Professor Stephens' work gives further support for the use of orthodontic PCDs. However I am sure that he understands that we would have found it rather difficult to cite an unpublished report, even though it would have been most relevant. In fact, we also were aware of the potential for politics to impede publication of our survey's findings, and were therefore very grateful that the British Dental Journal was prepared to referee and publish our paper.

How big can they get?

Sir,- This large sialolith (pictured) was removed from the right submandibular salivary gland duct of an 81 year old male whose presenting problem to his general dental practitioner was that his partial lower denture was ill-fitting. The operation was performed under local anaesthesia and clindamycin antibiotic cover as he is allergic to penicillin and has a history of prosthetic heart-valve surgery in 1993. Is this a record size?

H F Al-Bayaty

J E Scipio

R W Matthews

Trinidad and Tobago

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Sialolith measured in cm

Patient x-ray showing sialolith