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Priority will be given to letters less than 500 words long. Authors must sign the letter, which may be edited for reasons of space.

Competency based surgery

Sir, the subgroup for education of the Association of British Academic Oral and Maxillofacial Surgeons (ABAOMS) are currently working towards the production of a document outlining a competency based oral surgery undergraduate curriculum for the United Kingdom. As part of this process it was necessary to review a number of pertinent documents.[1-6] In addition, following the Bologna Declaration of 1999, we had to consider the guidance that has been distributed by DENTED, the Thematic Network Project Achieving Convergence in Standards of Output of European Dental Education.[7,8] The most recent document from this group outlines a profile and 17 competencies that all European dental schools will be expected to adhere to. The reviewing process for this document will begin in 2007 with the expectation of completion in 2009 for implementation in 2010.

The major competence of specific interest to our specialty is Domain VI in this document:

'*On graduation, a dentist must be competent to treat and manage conditions requiring simple reparative surgical procedures of the hard and soft tissues in patients of all ages, including the extraction of teeth, the removal of roots when necessary and the performance of minor soft tissue surgery, and to apply appropriate pharmaceutical agents to support treatment.*'

This major competence is dependent upon a number of supporting competencies, examples of which are given in the document but are subject to modification to suit *'national or regional needs'*. It is these supporting competencies 6.28 to 6.33 that need to be more prescriptive to reflect the level of surgical competency expected of UK graduates; at present there is a suggestion within the document that the graduating dentist should be *'competent to perform surgical extraction of an uncomplicated unerupted tooth'* (6.30). This, although achievable, is a definite move away from our traditional standard of a degree of ability to 'undertake the extraction of teeth and the removal of roots, where necessary utilising surgical techniques'[1] and would need further clarification of the 'uncomplicated unerupted tooth'. In addition to this there is a suggestion within the major competency text that 'minor soft tissue surgery' should be within the competence of a graduating dentist – this could be interpreted as biopsy, a subject of much recent public debate in this publication.[9,10]

The standardisation of a European competency based curriculum is to be encouraged but we urge each UK dental institution to contribute towards the feedback on this current document to ensure that everyone has an opportunity to contribute to the finalisation of what may become an essential standard in European dentistry and to ensure its clarity with regard to each dental specialty.

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J. Durham
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2. Quality Assurance Agency. *Subject benchmark statements. Academic standards – dentistry.* UK: Quality Assurance Agency, 2002.
3. DENTED document: core knowledge and understanding. http://www.dented.org/parse.php3?file¼content/knowledge.html
4. Advisory Committee on the Training of Dental Practitioners. *Report and recommendations concerning clinical competences required for the practice of dentistry in the European Union.* Document XV/8316/8/93. Brussels: European Commission, 1998.
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9. *Br Dent J* 2006; **200:** 242.
10. *Br Dent J* 2006; **200:** 363.

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A powerful stance

Sir, Dr Martin's editorial[1] on the dubious need for antibiotic prophylaxis in patients at risk from infectious endocarditis makes an authoritative powerful stance on a long-contentious subject.

The guidance given in the recent *Journal of Antimicrobial Chemotherapy*[2] does not go far enough to be of practical help in general practice. The recent *BMJ*,[3] quoting their new guidance for dental patients, says, 'These views remain controversial'. Patients themselves have expressed genuine concern as to the need for such high doses of antibiotic when they balance the infinitesimal risk of IE against the often certainty of vaginal candidiasis and the current medical climate of antibiotic restraint. The working party, accepting that a proper double-blind trial would be impractical due to the numbers involved, significantly did not raise the older argument that such a trial would be unethical. Of greater concern is their statement 'Many clinicians would be reluctant to accept the radical but logical step of withholding antibiotic prophylaxis. It was therefore agreed to compromise and recommend prophylaxis only for those patients in whom the risk was high.' A medical condition may constitute a risk in its own right but there is clear evidence that dental treatment contributes no additional risk. This equivocation makes it difficult to advise patients who deserve better substantiation. Indeed within the report there is an editorial comment 'This document was not subject to the journal's standard peer review process'.

We are aware that emphasis has shifted from procedure-related bacteraemia to cumulative bacteraemia. Roberts[4] has proposed that over a one-year period everyday bacteraemia provoked by normal oral function is six million times greater than the bacteraemia from dental extraction. That functional bacteraemia remains the same irrespective of the 'risk category.' The isolated events of dental treatment are therefore insignificant when considered against such endogenous bacterial exposure. A Cochrane Review[5] published this year advises, 'There is no

evidence to support the use of prophylactic penicillin to prevent endocarditis in invasive dental procedures.'

The culture of evidence-based dentistry has not progressed far when, confronted by such strong evidence, we retreat to this illogical compromise.

I. P. Hunter
Cambridge

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Supplying demand

Sir, I congratulate the authors on their excellent review of the *supply* of dental workers in the Shropshire and Staffordshire counties (P. Hornby *et al. BDJ* 2006; **200:** 575-579). However, the article barely touches on the *demand* side of the *supply and demand* aspects of a true workforce review.

In the Department of Health's *Review of the workforce*, published in July 2004,[1] this aspect received more or less equal weight. The review concluded that 'adult dental attendance will increase by 40% between 1998 and 2018'. Additionally, the review suggested that 'projections of adult treatment hours demanded imply a small overall growth in demand to 2011 (+5%) and a small decrease in the next 10 years (–3%). On a higher estimate, projections imply a larger growth between 2001-2011 (+7%) and very little growth from 2011-2021 (+0.1%)'.

Whilst I appreciate that this review was published late in this study, it is still referred to in this paper. The authors do not appear to have built these projections into their results.

Indeed, *demand* is referred to by the authors in only two paragraphs towards the end of their paper. They have based their estimates of needed workforce on an assumption that dentists see four NHS patients an hour – 126 patients a week – figures which were supported by the participants at workshops. However, figures produced by the Office of Manpower Economics, published as part of the 2000-1 Doctors and Dentists' Review Body Report[2] show that dentists working in the GDS were actually seeing 165 patients a week then. I know of no evidence published since then which indicates a lower figure – although an aim of the changes to the GDS contract introduced on 1 April 2006 is to effect a 5% reduction in workload. The same OME report did suggest that fully private dentists see less than 100 patients a week so, of course, the (anecdotally) reported shift by GDPs into the private sector may bring the average figures more into line with the authors' suggestion.

Finally, I do not understand the authors' assumptions about the use of hygienists and therapists and their contribution to the supply of dental workforce. Table 5 – which was a list of DPB supplied GDS treatment types – was extrapolated into figures for visits to dentists, hygienists and therapists, although the basis for these calculations was not shown. This led them to an assumption that only 54% of future visits need to be dentists.

I have no idea whether this figure is correct. We do not know if the authors took into account that all dental care must be preceded by an examination and diagnosis by a dentist. Also, we not are advised whether the authors allowed for the reduced output produced by dental care professionals, measured in WTEs, as suggested in the Department of Health Workforce Review.

I would welcome the authors' explanations.

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1. Department of Health (England) (2004) Report of the Primary Care Dental Workforce Review. www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4086050&chk=C2HjhP.
2. Office for Manpower Economics. *General Dental Practitioner's Workload Survey*. OME: London, 2000. Report prepared for the Doctors' and Dentists' Review Body.

Dr Peter Hornby responds on behalf of his co-authors: I should start by emphasising that we were commissioned specifically to look at the situation in Shropshire and Staffordshire. While we necessarily referenced other dental studies, including national reports, the basis of our report and the subsequent paper to the British Dental Journal *was drawn primarily from data and observations within these two counties. The demand side of our study, while given less emphasis in the paper because of restrictions in the length of the paper, was given equal emphasis in the actual study.*

We explored the demand side with the help of independent dental experts drawn from the local strategic health authority and using data on current and previous types of case mix volume. From this and available demographic information we projected growth in demand reflecting expert views about change in case mix with less restorative work occurring over time.

Our projection of 126 patients per week is indeed a lower rate than in the dentist review body report but was an attempt to reflect local dentist opinion collected through workshops and focus group meetings on what constitutes a reasonable workload level going into the future.

Detailed calculations were made about the potential contribution dental hygienists and therapists could make in dental services with appropriate training operating under the new regulations. They are based on judgements made by our dental expert colleagues through an analysis of projected case mix and workload and involved their judgements of which of the seven basic dental procedures could be allocated to each type of dental professional on the basis of competence to practise.

Our supply side assessment using Likert scales to provide a qualitative view of leaving intentions and related causal factors led us to identify emerging issues around gender and age which could impact significantly on the future availability of dental professionals in whole time equivalent terms. The brief for the study did not allow us to pursue its implications in depth through the development of alternate scenarios.

Our intention in all this was not to define in absolute terms through a single scenario the exact number of dental professionals required in these two counties in the future, but rather to show that there were routes through to overcoming dentist shortage in these two counties through changes in the approach taken to the provision of dental care and the training of dental professionals.

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Fee-splitting

Sir, the practice of 'fee splitting' has in the past been deprecated in the medical professions, sometimes in circumstances thought sufficient to justify erasure in certain General Medical Council cases. For those not familiar with the practice it means that the referring professional receives a part of the specialist's fee as incentive for referrals.

In view of this I was surprised and disappointed to see in a recent *BDJ* that an advertisement offered just this. Is this, in the early twenty-first century, now acceptable?

K. F. Marshall
Oxted

The Editor-in-Chief responds: I thank Dr Marshall for pointing the matter of this advert out to us, since it had passed by our scrutiny. In the event we have declined further adverts of the sort and I have written to the practitioner concerned to this effect, explaining our reasons. The current General Dental Council (GDC) guidance pertaining to the matter is contained in their publication Standards for dental professionals *and states in section 1.19: 'Never ask for, nor accept, any payment, gift or hospitality, or make or accept any referral, which may affect or appear to affect your professional judgement.'*

Reference to the former, more explicit guidance contained in Maintaining standards *stated in section 6.18 headed 'Incentives': 'The Council takes the following view with regard to the use of incentives: (iv) when referrals are made between professional colleagues no inducements should be offered or accepted.'*

Dr Marshall may rest assured that the beginning of this century has not seen a relaxation of this standard and colleagues offering or accepting such arrangements may leave themselves open to complaints to, and investigation by, the GDC.

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The Pareto principle

Sir, some background information on the history of the '80-20 phenomenon' will help readers and Dr Dugmore (*BDJ* 2006; **201:** 197-198) to understand why 'The phrase ... slips off the tongue so very easily'.

Vilfredo Pareto, an Italian economist (1848-1923) observed that 20% of the income in Italy was received by 80% of the Italian population and that 20% of the population owned 80% of the property. It was Joseph Juran, a management thinker who called the '80-20 rule' the Pareto principle. This '80-20 rule' has been found to apply in all walks of life and fits a variety of dental situations.

In the early 1970s I assembled teams of speakers for GDP dental practice management courses at numerous postgraduate centres in southern England. Several of the business management lecturers introduced the 'Pareto principle'. As a management concept this was introduced to help practitioners to direct their time and effort efficiently. On the courses we discovered a number of areas where this could be applied. One simple example was that 20% of the stock of goods held in a practice accounted for 80% of the value and this is where monitoring of use and wastage should be concentrated. Subsequently, on a visit to the Dental Estimates Board (later to become the Dental Practice Board) by the first group of dental vocational trainees we, and the Board, discovered that the GDP funding fitted the Pareto principle – 20% of the items of service accounted for 80% of the fees paid. Fittingly, this year, 2006, marks the centenary of the publication of Pareto's observation.

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Catastrophic occlusion

Sir, prophylactic occlusal equilibration is a popular form of treatment among some dentists in Sweden. The rationale offered is that by grinding the teeth so as to make an irregular occlusion better approximate to the textbook ideal, one can reduce the likelihood of the patient developing symptoms from their occlusal disharmony.

I had never heard of this treatment being used in the UK and no dentist had ever commented on my bite. However, after I had been living in Sweden for some years, a dentist here told me that my bite, which had never bothered me, was open at the front and that this was liable to cause problems in the jaw joint later on. He recommended and performed a wholesale occlusal equilibration of some 1 mm on all my molar occlusal contacts, and later claimed to have lowered the bite at the front by 3 mm. The results were catastrophic; from the day after the treatment until now I have suffered persistent, intense pain in the jaw joint and muscles and have difficulty swallowing, chewing and speaking. Since the dentist had not taken any models it has proven extremely difficult to restore my original bite. Sadly, I have subsequently discovered through my contacts with various patient organisations in Sweden that I am far from alone in what I have experienced.

Since this happened, I have explored some of the research on treatment and prevention of temporomandibular dysfunction and thus far have been unable to find scientific support for the use of prophylactic occlusal equilibration. Some researchers advise against it on the grounds that no benefits have been scientifically demonstrated and it is irreversible, injures the enamel and carries the risk of destabilising a functional bite. The procedure nevertheless apparently continues to be popular in Sweden. The dentist who treated me maintains that he will continue to use this method of prophylaxis and that it was simply bad luck that I reacted as I did. I wondered if readers had thoughts on this treatment.

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