and postgraduate training across both sectors. These recommendations were made in the 2010 report by Medical Education England[2] but have yet to be actioned.

BAOS has been lobbying the Tri-collegiate Specialty Membership Examinations' Executive regarding portfolio access to the MOral Surg examination for some time now[3] as well as holding discussions with the BDA[4] and the GDC. Portfolio access to the MOral Surg would greatly benefit the huge number of experienced OS staff grade, associate specialist and specialty doctors, who form a vital part of the team in many maxillofacial units, and we welcome the support of the British Association of Oral and Maxillofacial Surgeons in this.[5] These individuals have a wide scope of practice[6] and access to this examination would also augment any subsequent portfolio application for mediated entry to the OS specialist list. This approach works well for the GMC with its Certificate of Eligibility for Specialist Registration model.

Once on the specialist list, these individuals would be able to apply for OS consultant roles. This step is necessary to try and remedy the current shortfall in training posts, which is extremely important in the interim as an increase in OS national training numbers cannot happen overnight. This method of application is onerous and is in no way a 'back door' route on to specialist lists.

BAOS is ultimately concerned with gold standard delivery of OS for patients. Safe, high quality care for all undergoing OS in every environment is only attainable with adequate workforce numbers comprising properly trained, quality assured OS specialists and consultants. The excellent paper by Fullarton *et al.*[1] clearly demonstrates the need for robust workforce planning and illustrates that the lamentably low numbers of OS training programmes (45 in total in the UK) are currently insufficient to provide this.

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Oral health

IE advice

Sir, I was intrigued to read the article relating to infective endocarditis in the recent issue of your journal.[1] I agree with the authors that reliance on antibiotic prophylaxis is insufficient and prevention is key to reducing the risk. However, it should be emphasised that evidence has suggested bacteraemia can result from normal activities and is not limited to trauma to the soft tissue, as suggested to be the causative factor for the patient who possibly traumatised their gingiva using a toothpick. Mastication itself can increase the prevalence of bacteraemia by 17–51%, and dental flossing by 20–58%.[2]

A review by Roberts in 1999 suggested that it is far more likely these everyday procedures including tooth brushing and flossing are the cause of infective endocarditis rather than isolated random dental-induced bacteraemia that follows trauma. It is more likely that the cumulative exposure to bacteraemia from everyday activities increases a patient's risk of developing endocarditis as bacteraemia following dental procedures and isolated trauma to the mucosa is of low intensity and short duration.[3]

Therefore, by reiterating the advice offered by the NICE guidelines we focus on prevention and also the importance of case-selective advice.[4] The preventive advice must include providing patients at risk with information about symptoms that may indicate infective endocarditis. Additionally, emphasising to them the importance of good oral health in reducing their risk and reminding them about the risks of bacteraemia from undergoing other invasive procedures such as body piercing or tattooing.

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Occupational health

Published research on stress

Sir, we read, with interest, the letters of R. Bernstein[1] and R. Swainston[2] regarding the need for research to explore the emotional drivers of dentists, and particularly young dentists' distress. We also read the letter from GDPs in Peru[3] highlighting the apparent lack of a study evaluating primary interventions to deal with the dentists' stress.

We would like to point out that initial research into this area has already been conducted[4-7] and published in this journal. It resulted in an evidence-based self-help programme[8] which was both statistically and clinically effective in both the short- and longer-term. Participants in the research and programmes run to date have included a range of practitioners, from foundation dentists to established dentists in general practice. This programme has been made available to postgraduate medical education centres in the UK. It would also be possible to make it available elsewhere.

Our research and improvement of the stress/burnout coping skills package will continue, subject to research funding.

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