# Letters to the Editor

Send your letters to the Editor, British Dental Journal, 64 Wimpole Street, London W1G 8YS
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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.

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## PRAISE WHERE DUE

Sir, recently there have been two letters to the editor in the *British Dental Journal* which reported on a very uncaring attitude demonstrated by an NHS organisation when an employee had experienced devastating personal circumstances. This led to resignation (*BDJ* 2011; **211:** 151 and 2011; **211:** 244).

I would like to report that my experience in LCFT has been quite the reverse.

On Friday 20 May my husband and I were woken at 2am to be told that our 29-year-old daughter, who had severe learning difficulties and lived with us, had kidney failure. I emailed my Clinical Director to say that I would not be able to work on the following Monday and before 8am she had replied and taken over that worry. Every attempt I made to work or support our daughter was made as easy as possible by the whole dental team. Sadly two months later she died.

We were very touched that a number of staff came to the funeral.

After two months on sick leave during which no pressure has been put on me to go back to work and during which I have been well supported by all my colleagues, I am starting the slow return to 'normality', and going back to work.

During this time, we changed Trusts so all these arrangements have been even more difficult to organise and have had to be authorised twice.

I hope that I will be able to repay the support by continuing to work for the Trust. We are all very quick to criticise. I would like to praise where it is definitely due.

J. Bairstow
By email
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## JUST FOLLOWING ORDERS

Sir, an article/letter is always a pleasure to read as it will have been written from both the heart and the head.

M. Kelleher (*Abuse of dental practice*; *BDJ* 2011; **211:** 347) speaks of the 'elective destructive dentistry' which we all see coming into our practices from elsewhere, frequently under that dentist's pretence of 'I'm only doing what my patient asked/told me to do'. The criminal defence of 'just following orders' did not work in the Nuremburg Trials and our colleagues should not use it to justify their abuse of the patient's trust in their professional ethics.

Anyone providing a service to another has the option to state that the request will not be to that person's long-term benefit and that alternatives should be explored. If the potential recipient persists in their demand then the provider always has the option to decline to provide such treatment, and yet this option seems to be unknown to those providing 'elective destructive dentistry'.

C. Marks
Southampton
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## FOOD DEBRIS INDEX

Sir, measures of oral health are essential for epidemiological and clinical studies in order to provide accurate data for health promotion, prevention and therapy of diseases.

We recently performed an observational study on the oral and dental changes in a group of 12 elderly patients who were suffering from the chronic outcomes of stroke, including hemiplegia, and compared them with a healthy, matched control group.

There was an abundant accumulation of food debris in the mouths of the stroke patients which we were unable to classify with any of the existing indices[1-4] (plaque, oral health assessment and tongue coating). Although the Kaiser-Jones[5] Brief Oral Health Status Examination (BOHSE) assesses the oral cavity and surrounding tissues and considers oral cleanliness, the evaluation is limited to the presence of tartar and/or foods on teeth and dentures.

We propose the following index which considers debris accumulation in the left and right vestibular oral arches, as a complementary tool to other indexes of oral cleanliness.

The examination of the oral cavity begins in the upper right quadrant, proceeding clockwise to the lower right quadrant, with a time requirement of all four vestibular arches of less than 30 seconds. Each arch must be rated by assigning a score from 0 to 3 (Table 1).

Using this procedure we calculated the OFDI value for the left and right halves of the mouth and with reference to the whole oral cavity. The index appears to have good specificity and sensitivity: most of the healthy subjects (n = 11) recorded score = 0, with one registering score = 1; in contrast, most

**Table 1 OFDI, Oral Food Debris Index**

| Scores | Criteria |
|---|---|
| 0 | No food debris in the oral fornix |
| 1 | Pinpoint food debris, accumulation in the vestibular arch of food debris less than 1 cm long (<1 cm) |
| 2 | Accumulation of food debris between 1 and 2 cm (>1, <2) |
| 3 | Accumulation of food debris more than 2 cm (>2) |