Letters to the Editor

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LETTERS

GOVERNMENT LET DOWN

Sir, in your recent editorial (*BDJ* 2011; 211: 99) you expressed your surprise at the number of non-UK EEA dentists that are registered. I share your surprise. This has only happened because successive governments have not had proper manpower planning targets for dentistry (and medicine?) and as a result we have not trained enough of our own. Whatever opinion people hold regarding the non-UK EEA dentists the fact is without them there would be a shortage and this country would be the worse for it. On the other hand, if we had trained enough of our own, there would not have been vacancies and the Europeans probably would not have been attracted to this country in quite the same way. And can their countries of origin really afford to train dentists for us? The only conclusion I can draw is that in spite of what they tell us over many years our governments have let the NHS down by not ensuring that there are enough training places in this country.

R. Clark
By email

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ASKEW ADVICE

Sir, the latest advice statement from the Scottish Health Technologies Group¹ and the BDA's response of a 'common sense approach'² is, I believe, somewhat askew. The advice relates to patient safety/costs and steam sterilisation processes based on an assessment of the current literature and yet no details were provided on search strategy or methodology for undertaking systematic reviews. No references are quoted and the text of the advice statement '...

it was not possible to obtain the full text of other studies...' implies that not all the literature was reviewed on this topic! Interestingly, the Local Decontamination Unit Guidance for Scotland,³ the equivalent of HTM 01-05 in Scotland, was absent from the document. The advice statement does acknowledge that outcome measures 'appear to relate to biological measures of contamination ... rather than patient outcome' which implies that the author(s) were rather expecting randomised controlled studies on dental patients using the two different pieces of equipment, which is unlikely to achieve ethical approval especially since by the author's own admission one piece of equipment is likely to fail by biological criteria.

As the principal investigator in the study on dental handpiece decontamination referred to in the advice sheet I was not invited to present data on our current research. For cost-effectiveness, no work was presented on economic models of evaluation or risk assessments for transmission of infections in dentistry or other healthcare professions that use similar equipment. No details were provided on the equipment or its specification quoted in Table 1, therefore a meaningful analysis and economic appraisal of the two processes is not possible. No data were provided on capacity specifications of the equipment quoted in the costs. A large number of interrelated factors, for example instrument inventory, washer cycle times etc, affect throughput capacity determination; steriliser capacity is but one part. Technical inaccuracies in the costs provided in Table 1¹ (such as quoting the necessity for both Bowie Dick and Helix tests for a vacuum steriliser)

also undermine the accuracy of the advice statement.

Lastly, it is disappointing that the BDA have failed to scrutinise the shortcomings of the evidence presented in this advice and applauded this statement as a 'common sense approach'. Of course 'common sense' is often in the eye of the beholder as I'm sure that many familiar with technical challenges in achieving steam sterilisation would conclude that vacuum sterilisers when attempting to achieve sterilisation of wrapped and/or lumened devices are the 'common sense' option. Another 'common sense' test may also be to quiz patients on their willingness to participate in research linked to 'sterilisation failure'. In the past the BDA have quite rightly demanded an evidence-base for recent changes in infection prevention practice; this approach should be applied with equal vigour to all advice statements.

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1. Benchtop steam sterilisers in primary care advice statement 003/11. Scottish Health Technology Group. www.healthcareimprovementscotland.org/programmes/clinical_cost_effectiveness/shhg/advice_statements/advice/advice_statement_003-11.aspx
2. BDA applauds commonsense approach to decontamination in Scotland. BDA Press Release. www.bda.org/news-centre/press-releases/31407-bda-applauds-commonsense-approach-to-decontamination-in-scotland.aspx
2. Health Protection Scotland. Local Decontamination Units: Guidance on the Requirements for Equipment, Facilities and Management. 2007. <http://www.documents.hps.scot.nhs.uk/hai/decontamination/publications/ldu-001-02-v1-2.pdf>

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FREEDOM OF INFORMATION

Sir, we are receiving a growing number of requests under the Freedom of Information Act (FoI) to supply details of decisions made by the Primary Care

Trusts that relate to Individual Funding Review (IFR) cases. Each of these requests has considerable resource implications and means that what would have been allocated for patient care is being spent on bureaucratic processes.

Whilst we totally support the arguments behind the need for an FoI, its original purpose was to help ensure public accountability in decision making. It was not designed to help achieve an improved response rate for a particular research project, the value of which could be challenged.

We would suggest that those overseeing postgraduate projects ensure that when reviewing the methodology adopted for research it specifically excludes the use of the FoI Act as an instrument to try and improve response rates.

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JUST ANOTHER NUMBER?

Sir, 'time is money'. Nowhere else, it seems, is this phrase more poignant than in the NHS. Dentists, doctors and all other health professionals working for the NHS are restricted to strict targets, quotas and time limits. The very nature of having a suggested time limit for patient treatment/consultation leads to NHS dentists having very little time left (after taking medical history, diagnosing the problem, note taking and treatment) to spend on helping the patient on a more personal level. Although I am only a dental applicant, and have not yet started dental school, my work experience from a third-party perspective has raised some questions regarding dentist/patient relationships, and the contrast between this relationship in private and NHS practices. Does this in-and-out regime that many NHS dentists are forced to work under cause patients to believe they are just 'another number' on their dentist's ever-growing list? My opinion is that this lack of time to spend with patients contributes to many patients' bad attitudes in the surgery. I was quite taken aback by the difference in respect given towards dentists in NHS

and private practices, and it led me to consider whether the patient-dentist relationship (or lack thereof) was the deciding factor. Perfectly polite people become bad-mannered and short when on the phone to an operator in a call centre. Why? Because they know they are just another number on the operator's list, and once their conversation is over, they move on to the next number down. The person on the other end then goes back to their business. This shares some parallels with the NHS dental access centres. The patient comes in, receives their treatment and leaves as the next patient is ushered in. Although it is true that the dentist has many other patients to see, connecting with the patient and improving their experience is of great importance to all dentists, and of highest priority is patient care. In private practice, where the time restrictions are independently set, the dentist-patient relationship seems to be far better, particularly with the 'regulars'; they feel they know their dentist, and the dentist knows them. It seems that neither party benefits from the stringent time restrictions during the appointment, but then is time a luxury the NHS cannot afford for better patient satisfaction?

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SPHERICAL GREY VESICLES

Sir, herpetic gingivostomatitis is an infection of the oral cavity caused by herpes simplex virus type 1 (HSV-type 1). Although this infection is often seen in infants and children younger than six years of age, it can also be seen in adults.¹ Recurrent infection is commonly seen in adults due to various stimuli like sunlight, trauma, fever and stress. Recurrent infection has also been seen after initiation of dental treatment.² A female patient aged 45 years reported to the Department of Periodontics complaining of tartar on her teeth (Fig. 1). Oral prophylaxis was initiated using hand instruments and the patient was recalled three days later for further scaling. At the recall visit she complained of pain in the labial and buccal gingiva of the lower arch.

Discrete, spherical grey vesicles were noticed on the gingiva (Fig. 2) and she complained of a sore throat with tender and palpable submandibular lymph nodes. Based on the history and clinical examination a diagnosis of acute herpetic gingivostomatitis was made. The antiviral drug acyclovir was given for five days and palliative treatment included lignocaine gel and the analgesic drug paracetamol. The case serves as a reminder that age, although it may make a diagnosis seem implausible, does not alone exclude it.³

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Fig. 1 Clinical image before initiation of scaling

Fig. 2 Clinical image three days later, arrows point to the presence of discrete, spherical gray vesicles on the gingiva

1. Chauvin P J, Ajar A H. Acute herpetic gingivostomatitis in adults: a review of 13 cases, including diagnosis and management. *J Can Dent Assoc* 2002; **68**: 247-251.
2. Williamson R T. Diagnosis and management of recurrent herpes simplex induced by fixed prosthodontic tissue management: a clinical report. *J Prosthet Dent* 1999; **82**: 1-2.
3. MacPhail L, Greenspan D. Herpetic gingivostomatitis in a 70-year-old man. *Oral Surg Oral Med Oral Pathol Oral Radiol Endod* 1995; **79**: 50-52.

DOI: 10.1038/sj.bdj.2011.829