and 'curriculum structure' documents.^{2,3} Both updated documents were a result of intense European discussion not only from schools but dental associations and regulatory bodies. There was strong representation from the UK in this debate. Progress of the harmonisation of standards across Europe is occurring; the pace of change is difficult to measure but it is happening.

At a recent ADEE conference we received a keynote address⁵ from Professor Lesleyanne Hawthorne, University of Melbourne, on 'The Looming War for Skills: Global Demand for Foreign-Qualified Health Professionals'. This highlighted that movement of health professionals is not just peculiar to dentistry and certainly not only a European problem. There is a global shortage of skilled professionals and it does ask the question who will be filling the void for dentists in Eastern Europe and the Indian subcontinent? How many UK dentists look towards other countries to work such as the USA, Australia and New Zealand or even Europe?

The current European professional qualifications directive for open movement of professionals is being updated and a green paper has been released.⁶ ADEE has made representation to the EU commissioner who realises that the system of automatic recognition continues to offer an effective solution for the mobility of dentists. However, the preliminary report has highlighted the need for a minimum training duration and there is broad consensus that the duration of training is sufficient. There is debate for using European Credit Transfer System (ECTS) credits instead of years or hours to define the minimum training duration. An area where further discussion is required focuses on Annex V of the directive which covers dental training subjects. Dental professional organisations and competent authorities of several Member States favour an update of the list of dental training subjects in this annex. Several stakeholders favour the inclusion of a list of achievement of generic and subject related competences in the directive (output-based training). The EU commissioner is aware that the

Council of European Dentists and ADEE have made suggestions for updating this annex, which will lead to uniformity of training.

ADEE has focused on three points of interest in the directive and these include modernisation of training requirements, continual professional development and language skills (in particular communication skills). We have forwarded our documentation to the Commission as a ready-made European framework to be used for the training of dentists.

Therefore in answer to the editorial, we refute that there has been political failure and that 'Someone should do something'. The documentation and instruments already exist and are a way forward to harmonisation of European training.

A. D. Walmsley
W. Harzer

Association for Dental Research in Europe

1. Patel R, Eaton K A, Garcia A, Rincon V, Brooks J. An investigation into the numbers of dentists from 19 European Economic Area (EEA) member states currently registered to work in the United Kingdom and key differences between the practise of dentistry in the UK and their member states of origin. *Br Dent J* 2011; **211**: 133-137.
2. Hancocks S. One in three of us. *Br Dent J* 2011; **211**: 99.
3. Cowpe J, Plasschaert A, Harzer W, Vinkka-Puhakka H, Walmsley A D. Profile and competences for the graduating European dentist - update 2009. *Eur J Dent Educ* 2010; **14**: 193-202.
4. Manogue M, McLoughlin J, Christersson C et al. Curriculum structure, content, learning and assessment in European undergraduate dental education - update 2010. *Eur J Dent Educ* 2011; **15**: 133-141.
5. Hawthorne L. The looming war for skills: global demand for foreign-qualified health professionals. Keynote address ADEE annual conference, Helsinki, 2009. <http://www.videonet.fi/toebd/adee2009/la/2/index.html> (accessed August 2011).
6. Public consultation: Green Paper on Modernising the Professional Qualifications Directive. <http://www.epha.org/a/4639> (accessed August 2011.)

DOI: 10.1038/sj.bdj.2011.917

PROPORTIONAL TO THE INVESTMENT

Sir, I write in response to the letter of A. Smith (*Askew advice*; *BDJ* 2011; **211**: 305) regarding the advice statement¹ from the Scottish Health Technologies Group (SHTG) on benchtop steam sterilisers, and the BDA's response to this.²

Readers will be aware that the decontamination of dental handpieces has been a contentious issue for many years. As part of its ongoing review of decontamination requirements, the

Scottish Government's Dental Decontamination Group requested SHTG to provide advice on the use of vacuum sterilisers. The Decontamination Group is chaired by the Chief Dental Officer for Scotland and its membership includes Professor Smith and BDA representatives. The Group, as a whole, accepted the conclusions of SHTG.

It is also important to remember that the SHTG advice statement changed nothing; it did not impose any additional requirement on dental practices in Scotland, nor did it alter the current position that downward displacement (non-vacuum) sterilisers are acceptable in primary care dental settings. This is consistent with existing practice in England, Wales and Northern Ireland, where the government health departments recognise the uncertainty of current decontamination techniques consistently achieving dental handpiece sterility. Consequently, the use of vacuum sterilisers in primary care dental practices is not required by any government health department in the UK.

Regarding the BDA's comment on the SHTG statement, I can see no problem in welcoming an approach as 'common sense' where it is based on the principle that if there is insufficient evidence for a change in practice, limited resources should not be wasted imposing one. As with other issues in healthcare, only when the evidence base has been established can we then consider whether the health benefits likely to be gained are proportional to the investment they will require.

R. Kinloch
Chair, Scottish Dental Practice Committee,
BDA

1. Scottish Health Technology Group. Benchtop steam sterilisers in primary care. Advice statement 003/11. http://www.healthcareimprovementscotland.org/programmes/clinical___cost_effectiveness/shtg/advice_statements/advice_statement_003-11.aspx.
2. BDA Press Release. BDA applauds common-sense approach to decontamination in Scotland. <http://scotland.bda.org/news-centre/press-releases/31407-bda-applauds-commonsense-approach-to-decontamination-in-scotland.aspx>.

DOI: 10.1038/sj.bdj.2011.918

CULTURAL PREPARATIONS

Sir, the article *Investigation into the numbers of dentists from 19 EEA member states...* (*BDJ* 2011; **211**: 133-137)

reminded me of my own experience in 1951 after I had qualified BDS LDS at Manchester and applied to British Columbia for admission to their dental register. After some lengthy correspondence my Manchester degree was accepted but I was informed that I would have to complete two years of 'pre-dental' study before qualifying for general practice.

This was in fact to prepare me culturally and mentally to be a good and articulate Canadian.

When I pointed out that I was born in England of English parents and had attended six years of Manchester Grammar School (which then as now produced a high number of Oxbridge entrants), and that I had served two wartime years in the RAF, some time of that actually in Canada, spoke English fluently and could hold a knife and fork correctly, the two years pre-dental requirement was reduced to one.

The world was a different place then.

I stayed here, and finally retired in 2008.

B. Posner

Alderley Edge

DOI: 10.1038/sj.bdj.2011.919

NHS AMAZEMENT

Sir, I am amazed at the state of NHS dentistry in England. I am a UK graduate and worked faithfully in the NHS for 32 years before emigrating to New Zealand for a more outdoor lifestyle. I now have a grandson in the UK and decided to return for a few months each year to see more of him. I need an income to be able to achieve this, and thought I would easily get a locum job over here.

Imagine my dismay at finding it impossible due to the huge increase in bureaucracy. I need a performer number from the PCT, but cannot get one of these because I have not worked under the new contract. My only way around it is to work under vocational training for a year (not much good for a three month locum!)

I have seen several new contracts come and go, and would probably be able to work the new one out in all its little details in about a week. I have trained new dentists myself and feel I

know almost all there is to know about NHS dentistry and running a practice within its confines.

My CPD total is three times as high as it needs to be, as I always keep abreast of all new developments in dentistry. Without meaning to sound racist, my patients understand my English really well, and would welcome my doing a locum as a break from all the foreign accents in their practice.

What has become of the NHS? Thank goodness New Zealand still operates as a sensible, fair-minded piece of old England.

H. R. Read

DOI: 10.1038/sj.bdj.2011.920

THERAPIST OMISSION

Sir, I note once again the BDA seems to have forgotten that dental therapists exist. We have now been left off your information network form (*BDJ* 211[2]). I would like to think that many people now consider therapists as an important part of the dental team and my sensitive side is starting to feel hurt at this exclusion!

I have mentioned this on several evaluation forms after attending BDA courses. I hope you will consider changing me from 'other' to 'dental therapist' in the near future.

J. Hughes

By email

DOI: 10.1038/sj.bdj.2011.921

VEGETABLE GRANULOMA

Sir, Ghafoor *et al.* reported a case of submandibular radiolucency that led to subsequent correspondence in which Barrett questioned the authors' conclusion that the radiolucency was caused by displaced amalgam (*Not justified*; *BDJ* 2011; 211: 243).

As indicated by Barrett, implanted amalgam does not cause clinical granulomas, although it causes microscopical granulomas, and a tattoo can be the clinical result.¹ Vegetable can be implanted following extraction, and a vegetable granuloma can be the clinical result.² However, the poorly defined margin of the radiolucency and extensive resorption of the adjacent teeth, and the similar, poorly defined margin in the subsequent radiograph, are not

features of vegetable granuloma, but they are features of malignancy, which indicates the importance in such bizarre cases of clinical and histological investigations that are more extensive than usual.

J. D. Harrison

London

1. Harrison J D, Rowley P S A, Peters P D. Amalgam tattoos: light and electron microscopy and electron-probe micro-analysis. *J Pathol* 1977; **121**: 83-92.
2. Harrison J D, Martin I C. Oral vegetable granuloma: ultrastructural and histological study. *J Oral Pathol* 1986; **15**: 322-326.

DOI: 10.1038/sj.bdj.2011.922

TIME FOR CHANGE?

Sir, for many years the divide between dentistry and medicine has been evident; however, the integration of combined undergraduate teaching in some universities has gone some way to address this issue.

There still, however, appears to be a lack of basic dental knowledge amongst most new medical graduates, an issue that has become apparent during my time as a Senior House Officer in Oral and Maxillofacial Surgery at a busy regional unit.

A significant proportion of the attendances at hospital A&E departments that present with oral and maxillofacial conditions, could be sufficiently managed by medical staff ie incision and drainage of a dental abscess.

The on-call maxillofacial workload is already stretched, particularly at weekends due to the high number of trauma admissions and general ward work. Therefore simple cases not only place further demand on limited resources but also cause more patient distress through a prolonged assessment, diagnosis and treatment pathway.

Through further emphasis in the undergraduate medical course, it could be possible to create clinicians more confident and competent in the basic management of common oral and maxillofacial conditions.

Perhaps the time for change is here?

J. Flexen

Merseyside

DOI: 10.1038/sj.bdj.2011.923