Letters to the Editor

Send your letters to the Editor,
British Dental Journal,
64 Wimpole Street,
London
W1G 8YS
Email bdj@bda.org

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

BROWN HERB

Sir, a 60-year-old female of Somali ethnic origin presented to our undergraduate outreach primary care unit reporting a history of using a plant known as 'brown herb' to clean her teeth. The herb is reportedly fibrous and is rubbed over the teeth with a finger.

Despite no history of dental attendance there was little caries and no periodontal disease or soft tissue abnormality. There was extrinsic brown staining of all teeth.

The patient's daughter was concerned to know whether the 'brown herb' could risk malignant change. No dentists within the unit or the attached community clinic had heard of this oral hygiene practice before and a search of the literature was to no avail. The patient was advised to revert to the use of a conventional toothbrush and toothpaste. I wonder whether any of your readers can shed some light on the identity of 'brown herb' and its oral effects?

R. Carr
Cardiff

DOI: 10.1038/sj.bdj.2011.94

RUNNING THE ASYLUM

Sir, I have been in general practice for nearly 30 years and I endorse every word contained in D. Andrew's letter *Apprehension about the future* (*BDJ* 2010; **209:** 486-487).

Your editorial (*BDJ* 2010; **209:** 483) reads like a breath of fresh air but I fear the lunatics are now running the asylum.

N. Unsworth
London

DOI: 10.1038/sj.bdj.2011.95

AN UNMONITORED TREND

Sir, I have read with interest the recent correspondence relating to the increasing legislative requirements with which all GDPs are required to comply.

It would seem that the main problem for our profession, in our drive for increasing levels of quality assurance, is the increasing amount of time involved in providing the correct information to the relevant authority.

Having asked a number of well informed colleagues about the cumulative total of man-hours required to be fully compliant in all areas of providing dental care, no one seems to be in a position to say how much time is required.

Our problem could become that as the demands of all forms of quality assurance continue to increase, this may cause a significant reduction on the time available to provide treatment for our patients.

At present this trend seems to be largely unmonitored.

Under the circumstances, would it be unreasonable for the profession's representatives to insist all the relevant authorities state clearly in their guidance notes the amount of time expected for the completion of each assessment after first piloting the exercise?

With this information to hand we can then predict the point at which quality assurance assessments could become detrimental to the availability of patient care.

The alternative could be an increase in the number of stressed and disaffected individuals whose premature departure would remove from the profession many man-years of valuable experience to the detriment of the GDS.

P. Jackson
By email

DOI: 10.1038/sj.bdj.2011.96

THE OVERALL PICTURE

Sir, the study and paper by Johnson and Wildgoose (*BDJ* 2010; **209:** 287-292) has thrown up a number of important issues. These relate to removable prosthodontics and are part of an unsatisfactory situation that has been apparent for some while but is increasingly evidence-based.

Taken with other papers cited in the text, it is clear that UK undergraduate training is letting down badly our undergraduates and newly qualified, and consequently the patients under their care, by removing supportive prosthodontic teaching from the courses provided. The authors' account of the downgrading of this teaching is real and heartfelt.

We believe that the clinical example that was utilised as a basis for their study was poorly selected and we would consider the proposals then advocated to be flawed and difficult to support.

However, far more important, interesting and relevant is the overall picture of diminishing levels of experience and confidence of recent graduates, typically registered for three years, in making decisions involving necessary laboratory procedures such as partial denture design and construction.

This is further borne out by our own experiences of providing structured university postgraduate training. We can confirm that there are significant numbers of graduates who report having almost no undergraduate clinical experience, extending to never having made one partial denture in that time.

This should be sufficient to be raising major concerns and yet Clark *et al.* (*BDJ* 2010; **208:** E10) have reported equivalent problems, in connection with complete denture teaching. Pursuant to this, Clark