Letters to the Editor

Send your letters to the Editor,
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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.

LETTERS

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

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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

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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

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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

R, (Letters to Editor, *BDJ* 2010; 208: 44) was alarmed at the 'non response', even after inviting specific comment from the Chairperson of the GDC on this matter.

We fear that dental surgeons, on graduating and subscribing to the full weight of responsibility that comes with GDC registration, are increasingly not equipped to make clinically relevant decisions involving laboratory procedures nor to communicate in an effective and productive way with the technical support on which they will depend.

A. H. Croysdill

A. H. Eder

M. J. Faigenblum

London

A. Johnson and D. G. Wildgoose respond: Thank you for your letter regarding our article. The published literature, our own research and indeed your own observations do appear to confirm that undergraduate education in removable prosthodontics has suffered a slight decline over the last few years.

Removable partial denture (RPD) design and provision, rather than declining as many people predicted, is in fact now on the increase. As our ability as a profession to maintain teeth in people's mouths improves, the production of RPDs will increase, but will arguably become more difficult as provision will be for an ageing population.

Regular course review meetings held at the Sheffield Dental School and internal audits, one of which led to our paper, identified this problem and we made alterations to our RPD teaching with immediate effect, in 2007. The introduction of a new curriculum has enabled us to further strengthen the undergraduate learning and teaching in this area.

We now introduce the basic concepts of RPD design to our 2nd year BDS students, just prior to them treating their first RPD patients requiring acrylic resin RPDs. More advanced concepts are taught in 3rd year when they are likely to be treating patients who require metal RPDs, which may also involve crown and bridgework as part of the treatment plan. Dedicated treatment planning clinics are used to provide students the clinical and technical advice they need to provide high quality patient care. Our 4th and 5th year out-

reach programme also allows students the opportunity to treat patients requiring RPDs. All this is intended to provide the student with a continuing thread of RPD experience, which runs throughout the entire BDS course.

We are satisfied that our students are exposed to a comprehensive and coherent learning experience in RPD provision that will ensure that they reach a level of competence that would be expected from a graduating BDS student.

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ORAL HEALTH THROUGH SPORT

Sir, we would like to bring to your attention a new initiative developed this summer at the Brit Insurance Oval cricket ground in South London. Health promotion at major sports stadia is not a new concept and many professional football and rugby clubs routinely hold events on match days promoting healthy lifestyles for spectators and stadium staff. To date, oral health has not been promoted at these events despite serious diseases such as oral cancer, so in order to address this a small consortium of health and sports stadia professionals set up a new campaign, 'Boundaries For Life', to provide a free medical and dental screening service to fans at international cricket matches. A holistic screening service, including the oral mucosa, was offered to spectators and staff, who were invited to complete a short confidential questionnaire and undergo a brief health screen involving measurement of blood pressure and body mass index.

The event was launched at the one-day international between England and Pakistan in September 2010 where our team of volunteers including doctors, dentists, nurses and medical students provided the free service to 31 participants. The results of the exit questionnaire were very positive, where 71% of participants scored the dental screening initiative very highly in terms of usefulness. We also identified patients who had a family history of mouth cancer and they were given preventative advice and leaflets, which were kindly donated by the British Dental Health Foundation.

We believe the scope for promoting oral health at sports stadia is under-utilised and that target populations which

may be considered as hard to reach and in which the prevalence of conditions such as mouth cancer is high may be reached. For example South Asian populations, for whom cricket is tantamount to a religion, may engage with oral health promotion through sport.

Given the limitations with access to NHS dentistry we felt that targeted, free oral mucosal health checks at major sporting events is a valuable resource in the early detection of oral cancer. It is also an opportunity to promote oral health in the wider context of general health, raise awareness of the importance of oral cancer screening to our medical colleagues and raise the profile of dentistry by participating in sporting events at all levels.

As a result of the success of our pilot event we are hoping to launch more initiatives at other sporting events across the UK and are currently in negotiation with national sporting bodies and stadia to promote oral health in sporting venues. Boundaries For Life would like to thank Birwood Dental Care, The Brit Insurance Oval, Southern Medical Services, and European Healthy Stadia Network as the key stakeholders in this initiative as well the volunteers who gave up their time.

C. Trivedy

Founder of the Boundaries

For Life initiative

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AN OUTDATED PRACTICE

Sir, I agree with the views of Dr A. Peters Reid in *Needless waste* (*BDJ* 2010; 209: 591). I feel passionately about this matter, as a newly qualified dentist, and feel that the Department of Health are wasting a valuable resource to the National Health Service. With current and improving standards in cross infection control, risk of HIV transmission is indeed minimal. As such it seems to me that not allowing an experienced dental practitioner to practise is outdated. There should be further research into this matter, particularly when you consider that general dental practitioners are allowed to practise in the USA, Australia and Europe.

R. Sharma

Liverpool

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