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.

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LETTERS

WHERE DOES CHANGE BEGIN?

Sir, in reply to the letter in a recent edition of the *BDJ*, *Different priorities* (*BDJ* 2011; 211: 447-448), I should like to add my comments. I am the Dental Coordinator for Christian Relief Uganda (www.christianreliefuganda.org).

I was present at the conference in Manchester where Dr Holmgren spoke.

For six years we have run pain relief dental clinics in the rural areas and some of the prisons of Uganda, which include oral health education programmes and talks against the malpractice of infant oral mutilation. We do this in cooperation with the indigenous dentists, enhancing their skills by bringing UK dental personnel out to Uganda, who work alongside them as they treat their own people.

Our supporters have funded the further dental education of several Ugandan dentists who plan to approach government to begin work on policy change.

Working with a Ugandan visual aids company, we have designed culturally appropriate oral health education posters and booklets which our Ugandan colleagues use at outreach clinics.

Where does change begin? We have chosen to start with the roots. Who can tell where the branches may reach?

B. Koffman

Christian Relief Uganda

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COUNTERSIGNATURE CODE

Sir, I write regarding the editorial *Antibiotic stewardship* (*BDJ* 2011; 211: 443). This excellent editorial not only serves as a warning on how serious bacterial resistance is becoming but also outlines important steps which should be taken as a matter of urgency to protect the

public going forward. Using a combination of close adherence to antibiotic prescribing guidance, additional information provided by the Medicines Information Service where appropriate and 24 hour patient review, I now prescribe antibiotics approximately twice annually (full time, predominantly NHS general dental practice). I also note that in a recent *BDJ* paper (*An outcome audit of three day antimicrobial prescribing for the acute dentoalveolar abscess*; *BDJ* 2011; 211: 591-594), close adherence to prescribing guidance was reported to have produced a very good antibiotic prescribing profile of only 2.9% of patients presenting with pain at a primary care department.

Furthermore, initial results from a (quite possibly non-representative) survey of antibiotic prescribing habits of dentists using a well known online dental discussion site suggest that approximately 66% of practitioners are using local measures alone for management of non-systemic acute apical periodontal abscesses. Approximately 20% of practitioners reported using antibiotics in conjunction with local measures (a proportion of this group may be in the process of 'converting' to local measures only). If these figures are approximately correct, then it suggests that there is probably good adherence to prescribing guidance.

Despite this, and bearing in mind the editorial referred to above in particular, I am of the opinion that a 'dual key' approach should be adopted for antibiotic prescribing in primary dental care. In this approach, when primary care dentists wish to prescribe antibiotics, they would contact Medicines Information or an appointed network of special-

ists (with out of hours cover) to discuss the patient's clinical status.

Following the discussions, if both clinicians agree that immediate prescribing of antibiotics is indicated, the support service would issue the primary care dentist (NHS or private) with a 'countersignature' code which would be included on the prescription along with any other agreed details of the support service contact.

In circumstances where there was disagreement, a third opinion would be sought from a third clinician. This system would provide additional protection to the patient and the primary care dentist. In the longer term it is conceivable that an artificial intelligence application could be developed for the purpose and thereby replace the need for a manned 24 hour service.

Unlike peak oil which is yet to be reached, I suspect peak antibiotic effectiveness has been passed and the situation is still deteriorating with very serious implications for our children.

P. Mc Crory

By email

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COMMUNIST WITCH HUNT

Sir, we have recently had our pedal bin updated to comply with CQC and HTM 01-05 guidelines and discovered it had 'soft clinical waste' written in Braille upon it, presumably so as not to discriminate against a blind dentist disposing of his waste.

Society seems to have changed from one where problems were identified and solutions found, to one which seems to mimic McCarthy's 1950s communist witch hunt. If the risk management is to be believed, there should have

been hundreds of patients that I have inadvertently killed with myriad infections from the treatments that I have provided. I am pleased to say that to my knowledge there have been no dentally related cross infection deaths reported from whatever cause in the 30+ years I have been in practice.

My comments may seem flippant, but I yearn for a return of some scientific common sense and practice. It would be much easier to stomach the changes if the infection rates were published. Then we can advise patients that we are protecting them from real and known evidence-based problems. To my mind, this is either because such evidence does not exist, or because the kneejerk reaction nowadays is to say no risk, however theoretical, is acceptable. It is possible that such evidence is out there, but not being presented. A quick internet search for dental acquired infections leads to the relationship between hospital acquired infections and periodontal disease, which is not the same thing at all. I seem to remember the Shirley Glasstone Hughes research question about cost effectiveness could not be answered because there was no published evidence that there was a problem.

At least with BSE and beef on the bone, precautions were placed, but when the evidence did not support the hypothesis, the expensive solution was abandoned.

I do feel very let down by our professional representatives, both the BDA and the FGDP(UK). These changes are horrendously expensive, and patients will have to pay for them in the end. Why could they not fund the research necessary if that is what it takes to answer the question, or widely publish the evidence if it is there?

D. Earp

By email

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A DISTINCT SADNESS

Sir, we, being the past Director of the Edinburgh Postgraduate Dental Institute, the current Programme Director for the MSc in Primary Dental Care and the Interim Director of the Institute, read the letter from Dr Steven (An advised choice; *BDJ* 2011; 211: 505)

with concern. It is a profound disappointment when an individual finds their postgraduate experience less than satisfactory.

We have the greatest respect for colleagues who commit to longitudinal formal programmes of postgraduate dental education. It is a significant commitment and for the overwhelming majority the benefits have been worth the costs whether these are financial, personal or both.

Formal postgraduate dental education leading to a university certificate, diploma or master's degree represents a major, perhaps once in a lifetime, opportunity. So when things do not turn out well, it is disappointing all round. We are grateful that for most people, the professional rewards in terms of personal development, both in the short but usually more in the long term are worthwhile.

It would not be appropriate to discuss here Dr Steven's specific complaints and this letter is limited to general observations. However, there is opportunity to discuss a number of points, which may in turn help those considering formal postgraduate education.

Firstly, do research the courses available carefully. Not only is it important to talk to the organisers but it is perhaps even more important to seek the views of those postgraduates currently taking the programme. Each programme is different, even if they have the same title, and the way the education is delivered will suit different individuals' learning styles.

Secondly, consider the timing of the application to study for a postgraduate degree. It is a significant commitment of time and postgraduate students need to be able to give that time and be willing to sacrifice other elements of their personal and professional life to do it. The work commitment is generally continuous with periods where it becomes intense. It is this ability to engage and immerse oneself in the course that is perhaps the greatest challenge and is key to progression, whilst in turn the challenge for the university is to develop and support that commitment by strong engagement from the teaching staff.

A master's degree is awarded 180 university credits – that is equivalent to 1,800 hours of learner effort – whether part-time over three years or full time over one, it is a significant achievement, never to be underestimated.

At a personal level, we are grateful to Dr Steven for recording his concerns: we will reflect on what he has written and undoubtedly learn from it. Overall, we are left with a distinct sadness that his own postgraduate experience was not the one that he had hoped for.

R. Ibbetson, O. Lawrie, A. Anderson

By email

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NO PLACE FOR COMPLACENCY

Sir, the letters from Dr R. Coleman and C. J. Holmgren and H. Benizian (*BDJ* 2011; 211: 447-448) were shared with two Ugandan dentists who work closely with Christian Relief Uganda (CRU) dental missions, providing pain relief clinics to the rural population which has little or no access to oral care.

Holmgren and Benizian state '*The paramount objective of volunteer work should be to support and strengthen a local weak or insufficient healthcare system so that all urgent health needs can be appropriately addressed at all times.*' Apolo Mukisa is a public health dental officer at Kabale Referral Hospital and is currently studying dental technology at Mulago Dental School. He comments '*We have here two scenarios – one dentist in support of secondary intervention and the other group for policy and primary intervention. Both groups have done work, which is commendable but I like the approach of our own CRU dental programme which combines both approaches in a holistic manner, highlighted as follows:*

1. Capacity building (training and empowering local dentists)
2. Resource mobilisation. Volunteers, supplies, finance etc
3. Collaboration with other agencies, organisations, both local and international
4. Developing and strengthening policy mechanisms, dental literature, etc
5. Oral health education
6. Emergency pain relief clinics