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. Benzion (*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 Benzion 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