service working with a proportionate regulatory system.' In front of the Health Select Committee the Registrar continually referred to the word 'proportional'.

There is a principle in the Civil Procedure Rules referred to as the 'overriding objective'. The principle also applies to those professions under the Professional Regulatory Authority. The overriding objective includes the proviso that cases should be dealt with in ways that are proportional to the nature, importance and complexity of the issues. Is a notice of erasure and subsequent oral appeal for a shortfall of 48 hours of non-verifiable CPD important? Is it complex? Does it warrant the Council's threat to instruct solicitors and counsel with a possible costs order of £6,000 in the event that the appeal fails?

The proportionality issue was enhanced by the fact that only six days before my appeal a policy paper '*Enhanced continuing professional development scheme*' was put out for consultation. This in effect recognised the short comings of non-verifiable CPD as a box ticking exercise with little recognition of learning outcomes. The Council never referred to this policy document and the Committee were unaware of its existence.

The determination not to erase my name from the Dentists Register gives me little pleasure. Apart from registrants having to fund the all-day hearing, there are probably many cases in the pipeline that are completely out of proportion to the alleged wrongdoing.

E. Gordon
Finchley
DOI: 10.1038/sj.bdj.2015.304

Editor's note: further information about this particular case can be found in the news section of this issue.

THE POWER OF DATA

Sir, we are waiting impatiently for the outcome of the review of the current situation in the UK regarding antimicrobial prophylaxis against infective endocarditis (IE) and the 2008 NICE guidelines (GC64) as announced by NICE in November 2014.

The research work that has finally motivated this immediate re-evaluation has been recently published in *The Lancet* by a group of British and American professors in cardiology, oral medicine and infectious diseases.[1] They conclude that prescriptions of antibiotic prophylaxis have fallen substantially and the incidence of IE has increased significantly in England since the introduction of the 2008 NICE guidelines. This is not just a key moment for all our dental colleagues but also a hugely inspirational event, which, once again, highlights the importance and the power of data. It reinforces the need for data collection and, I imagine, pays off all the hard work invested in a national research project of that scale.

I cannot further emphasise enough that all dental professionals should be competent on recognising the signs and symptoms of IE, remain informed about such a potentially fatal pathological entity and be aware of how its diagnosis is reached and what its initial management involves. This valuable knowledge will allow us to explain the rationale behind the current guidelines and probable future changes, better educating our patients and most importantly promoting preventive dentistry and medicine to reduce the overall risk.

Perhaps, as Bach has very rationally suggested, until more definitive trials are performed, involving patients in an informed decision-making process and individualisation of cases, in liaison with our cardiology colleagues, when antibiotic prophylaxis is considered, there seems to be a more ethical approach.[2]

A. De Gea Rico, L. R. Williams,
London

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2. Bach D S. Antibiotic prophylaxis for infective endocarditis: ethical care in the era of revised guidelines. *Methodist Debakey Cardiovasc J* 2010; **6:** 48–52.

DOI: 10.1038/sj.bdj.2015.307

DENTAL PUBLIC HEALTH

Community action

Sir, thank you for your editorial advocating water fluoridation as a safe and efficacious measure to assuage the physical, economic, social, psychological and emotional repercussions of dental caries.[1] Regrettably, dental caries remains a major public health concern in high and low income countries; wreaking havoc on entire communities, bringing in its wake anguish, torment, starvation, weight loss, growth retardation, health and social inequities and even death. The mouth is the gateway to our bodies and intuitively, oral and systemic diseases share common risk factors/pathogenic pathways.[2] It has long being argued that oral and systemic health are determined by a multitude of common risk factors from dietary intake, smoking, alcohol consumption and poor oral hygiene to commensal microbial communities colonising our mucous membranes, destabilising our oral ecosystems and causing diseases

The global nature of health in contemporary times is complex, as was demonstrated recently during the Ebola virus outbreak in West Africa; human health is inexorably intertwined with a rich and diverse tapestry of political, economic, social, animal, cultural, ethical, religious, behavioural, digital and environmental underpinnings.[3] The situation is further complicated by the budding of public, private and non-governmental factors with absolute shrinking in the sovereignty and realm of governments. Oral health cannot be seen in isolation. Therefore, health strategists can enhance oral and general health by encouraging community involvement, group spirit and partnerships, and emphasising the relationship between oral and general health within a prosperous society.

M. F. Al Qutob
London

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2. Sheiham A, Watt R. The common risk factor approach: a rational basis for promoting oral health. *Community Dent Oral Epidemiol* 2000; **28:** 399–406.
3. Bhopal A. Attitude and the 21st century doctor. *Lancet Glob Health* 2015; **3:** e126–e127.

DOI: 10.1038/sj.bdj.2015.305

EQUIPMENT QUALITY

Counterfeit cables

Sir, I write in relation to your recent editorial *The artfulness of the fake* (*BDJ* 2015; 215: 317). I would like to inform of an experience which I had recently.

I purchased an iPad mini as a Christmas gift for my disabled sister-in-law in 2013 from Apple store. I received a beautifully packaged product with which she was delighted. Unfortunately, two months later it would not charge because the device decided that the charging cable was a counterfeit (supplied by Apple).

My sister-in-law's Lithuanian carer gave her a cable which she had purchased in the local market for $2 which is working perfectly! Makes one wonder.

J. Gilleece
By email
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