numbers coloured red from other numbers to create a PIN!)

Most of this debate may soon be moot, as about 80% of CPI cases can have their colour vision corrected by a new invention of CPI-correcting glasses.⁶ It will take time for them to become mainstream, but seeing is believing.

To find really useful, detailed thinking on the subject of equality and diversity in the medical profession, including CPI, I recommend the various guidance documents and information pieces provided by the BMA (I declare a past interest). The resources provide appropriate, concrete help and, most importantly of all, are written with a great deal of humanity.^{7,8}

C. Seddon, Cardiff

1. City, University of London. A new web-based colour vision test. Available at: <http://www.city.ac.uk/health/research/centre-for-applied-vision-research/a-new-web-based-colour-vision-test> (accessed 6 September 2016).
2. Equality Law. New colour blindness test reduces barriers to safety critical work. 5 October 2012. Available at: <http://www.equality-law.co.uk/news/2736/60/New-colour-blindness-test-reduces-barriers-to-safety-critical-work/> (accessed 6 September 2016).
3. Freeths. Could a ban on colour-blind recruits be discriminatory? 21 October 2014. Available at: <http://www.legalrss.co.uk/freeths/could-a-ban-on-colour-blind-recruits-be-discriminatory> (accessed 6 September 2016).
4. Color Blindness. Ishihara Color Test. Available at: <http://www.colour-blindness.com/colour-blindness-tests/ishihara-colour-test-plates/> (accessed 6 September 2016).
5. COPDEND. Satisfactory complete of Dental Foundation Training project equality impact assessment. 5 March 2015. Available at: <http://www.copdend.org/data/files/Downloads/EIA%20Satisfactory%20Completion%20of%20Dental%20Foundation%20Training%20V2050315.pdf> (accessed 6 September 2016).
6. EnChroma Color for the Color Blind. Available at: <http://enchroma.com> (accessed October 2016).
7. BMA. Reasonable adjustments for students and doctors with disabilities. 7 December 2012. Available at: <https://www.bma.org.uk/advice/work-life-support/your-wellbeing/reasonable-adjustments> (accessed 6 September 2016).
8. BMA. Nobody's perfect: how physical characteristics impact on medical careers. 28 January 2012. Available at: <https://www.bma.org.uk/news/2012/january/nobody-is-perfect> (accessed 6 September 2016).

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Are dentists avoiding their metaphorical vegetables?

Sir, I read with interest the results of a survey of dentists in the UK regarding perceived deficiencies in their dental school education.¹

'Soft skills' such as communication, ethics and professionalism were not seen as deficient, and only 10% regarded communication skills to be an important addition. Communication is recognised as a vital aspect of patient centred care. It plays an essential role in patient risk assessment, behaviour modification and integration with the rest of the healthcare team. A large proportion of patient complaints relate to these skills, including a lack of consultation in treatment planning and absence of informed

consent. This indicates there is likely a gap between the level of communication skills thought necessary by the public and the dental profession. This is reflective of the growing tension between professionalism and commercial survival. As such, a picture of potentially imbalanced priorities emerges between the wishes of patients and dentists.

In contrast, there is a growing understanding within the academic sphere of the role of universities in nurturing an ethical, socially responsible profession through curricula design. Dental school directors are in a position to question their role balancing the development of training quality healthcare professionals and the wishes of students. When considering an addition to the curricula a question needs to be asked: should students be given vegetables or dessert?

It is this reader's opinion that the time where schools have students effectively held hostage is better served by promoting the skills which will best improve the quality of care received by patients. Whilst I recognise the important role business skills will have in dentists' workplace quality of life, development of these skills may be better suited to CPD post-graduation. In a time of heavily congested dental curricula it is important for those involved in the education of new dental professionals not to be swayed by the desires of their student consumers, but to keep focused on the wider social picture.

S. Lew, Melbourne, Australia

1. Oliver G R, Lynch C D, Chadwick B L, Santini A, Wilson N H F. What I wish I'd learned at dental school. *Br Dent J* 2016; **221**: 187–189.

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Local area inspection

Arbitrary administrative rules

Sir, I was recently inspected by the Buckinghamshire Local Area Team (LAT) during which a patient's records were examined including a root canal treatment before and after radiographs. The patient had initially presented with pain and there was a draining sinus. The treatment I provided successfully resolved the pain and the sinus healed. Therefore, I was surprised when the LAT inspector informed me that this treatment was 'negligent' because I had not recorded any justification for proceeding to crown the tooth. Crowning a root filled molar tooth is simply following a well-established treatment pathway, and as such is no different to, say, filling a prepared cavity or suturing a surgical incision.

I wondered if this strange finding was a misguided attempt by the LAT to save money (a crown attracts a greater number of UDAs than a root filling alone), but seemingly not, because the other 'misdeemeanour' they picked up on involved a check-up and scale and polish provided for a young teenage girl. The scale and polish was not justified in terms of periodontal disease and therefore – according to the LAT inspector – was 'negligently provided'.

This patient does not have periodontal disease but she likes the feel and appearance of having cleaned teeth. Surely this is something we should encourage patients to appreciate for bringing long term personal and health benefits. Cleaning this young lady's teeth brought no additional payment whatsoever; I would have been paid exactly the same if I had not bothered. I went to the trouble of cleaning her teeth because she wanted them cleaned, and because I believed it was the right thing to do: I was just doing my job.

These two matters (and possibly others that were not discussed at the time) are now to be considered by a disciplinary committee who will decide what action is to be taken against me. This encounter with authority highlights some very worrying issues, which should be of the gravest concern to anybody concerned with the quality of dental services provided in this country. It seems that dentists are no longer judged by what really matters: honesty, competence and personal standards. Instead we are judged according to our compliance with arbitrary administrative rules, and the truly important is ignored.

R. Mackay, by email

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Dental patients

The true value of every appointment

Sir, I'm currently a third year dental student at Peninsula. During my second year of dental school I was given a community engagement project involving young mums. During a dental school visit, I was involved in a simulated dental appointment that was being watched by a young mum who was very anxious of the dentist. The simulated appointment was 10-15 minutes long and was regarding what a normal check-up entails and what instruments are commonly used. We later found out that this individual signed up to see a dentist based upon what they saw at the dental school. This opened my eyes to how much of an impact we can have on a person's life and dental health

in such a small amount of time. Without even treating this individual, we may have changed not only their dental health for life, but also their child's dental health.

This experience led me to understand the true worth of every minute of every dental appointment. Whilst it may be something we do day in day out, to others it is a strange and memorable event and so everything we say or do will possibly have a long lasting effect on a patient. Some of us may think that a full set of new anterior crowns or braces can change a person's life but based on this experience, I feel that even a single check-up can change a person's life and/or dental health for life. A new patient who comes into your clinic tomorrow may become a lifelong patient of your practice based off that single 15 minute appointment. I'm sure we all understand the positive benefits of this to the patient's lifelong dental health and possibly even their friends or family.

I think that if we all carry this thought throughout our dental careers it will not only be beneficial to our morale and motivation, but also to patients and the general perception of dentistry.

A. Jafarian, by email

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Antimicrobial resistance

The Glasgow OMF model

Sir, in response to the letter by Singh¹ highlighting the challenges of the infection workload in oralmaxillofacial (OMF) surgery and access to microbiology advice from clinical oral microbiologists (COMs) we outline how the service is utilised in Glasgow. In NHS Glasgow and Clyde Region there is one clinically active oral microbiologist who works with the maxillofacial services at the Queen Elizabeth University Hospital (QEUPH) and Glasgow Dental Hospital. The regional OMF unit runs a trauma and surgical oncology service that includes management of severe odontogenic infections. There is a weekly ward round (Tuesdays 08:00) with the OMF team where cases, microbiology specimens, results and antimicrobial treatment plans are discussed and reviewed. Microbiology reports being reviewed the previous day from the laboratory e-reporting system by the COM. This process provides a vital antimicrobial stewardship link with improvements in clinical outcomes. An example of this is the move towards more prolonged antimicrobial treatment of complex ORN/MRONJ cases in collaboration between OMF with the outpatient

antimicrobial treatment (OPAT) unit. The key to success of these interactions is teamwork as the COM is embedded in the medical microbiology services who combine to support a 24-hour and 365-days-a-year service to OMF. However, this system does have its challenges as the COM is a clinical academic under the usual pressures for publications and grant funding. Furthermore, the diagnostic facilities are no longer located in the dental hospital which entails travelling to different sites.

In terms of undergraduate awareness of COM clinical training and scope of practice, ACOM and others have been lobbying for an increase in training numbers to the COM specialty for a number of years and have recommended to the Council of Dental School Deans that every school must have access to this level of academic and clinical support. In response to the scenario described in the letter the answer is the one that provides the best clinical outcome for the patient, ie multidisciplinary teamwork that includes access to a COM is the way forward. Perhaps pressure from the commissioning guide for dental specialties² and activity by the postgraduate deaneries to create COM training posts will help improve patient outcomes from infection by improving access to expert advice?

A. Smith, C. MacIver, J. McMahon, C. Wales,
I. Holland, by email

1. Singh N. Antimicrobial resistance: COMs and OMFs. *Br Dent J* 2016; **221**: 101.
2. NHS England. Commissioning Dental Specialties - Supporting Specialties. (In press.)

DOI: 10.1038/sj.bdj.2016.800

OMFS

Do your research

Sir, in response to Ms Ahmed's letter,¹ we support and add to Jennifer Graystone's online comments. We were the first dually qualified, surgically trained, FRCS positive, oral and maxillofacial surgery (OMFS) consultant couple in the UK, possibly in the world. We know, first hand, that careers in OMFS are compatible with family life (although our offspring Tom and Catherine might hold contrasting views).

We kindly suggest to Ms Ahmed that, before going to print, it is always beneficial to undertake a search of the literature, or at least Google. Surgeons must resist the temptation to extrapolate from the specific to the general without reviewing current evidence. At the British Association of Oral and Maxillofacial Surgeons Annual Scientific Meeting in

Brighton this summer, we presented a poster on Gender in Oral & Maxillofacial Surgery (OMFS) which is available to view on ResearchGate.²

Had Ms Ahmed found this poster, she would know that the first female OMFS consultant was appointed in 1967. In 2016, of 561 specialists and trainees identified in our study, 61 (11%) are female making up 8% of consultants and specialists (n = 31) and 20% of trainees (n = 30). This compares favourably with other surgical specialties but there is clearly more progress to be made.

Finally, she might also have found two papers published online in the *British Journal of Oral and Maxillofacial Surgery* on 'Push' and 'Pull' Factors in OMFS which discuss the factors which draw and repel both genders to our specialty.^{3,4}

A. Begley, P. Magennis, by email

1. Ahmed A. OMFS: Gender imbalance? *Br Dent J* 2016; **221**: 372.
2. Magennis P, Begley A. Gender of OMFS trainees and consultants change with time, first degree and risk of training failure. June 2016. Available at: <https://www.researchgate.net/publication/308948818> (accessed October 2016).
3. Kent S, Herbert C, Magennis P, Cleland J. What attracts people to a career in oral and maxillofacial surgery? A questionnaire survey. *Br J Oral Maxillofac Surg* 2016; doi: 10.1016/j.bjoms.2016.08.022 [Epub ahead of print].
4. Herbert C, Kent S, Magennis P, Cleland J. What causes trainees to leave oral and maxillofacial surgery? A questionnaire survey. *Br J Oral Maxillofac Surg* 2016; doi: 10.1016/j.bjoms.2016.08.023 [Epub ahead of print].

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Erratum

Transforming the registers

The above letter, published on 23 September 2016 (**221**: 280), was erroneously published with only one reference listed at the end, although three references are cited in the text of the letter. The full reference list should have been published as follows:

1. General Dental Council. Consultation on removal of registrants' full addresses from the online register. Available at: <http://www.gdc-uk.org/GDCalendar/Consultations/Pages/removal-of-registrants%E2%80%99-full-addresses-from-the-online-register.aspx> (accessed July 2016).
2. General Medical Council. Consultation on developing our online register. Available at: <http://www.gmc-uk.org/doctors/LRMPconsultation.asp> (accessed July 2016).
3. General Medical Council. Reviewing the List of Registered Medical Practitioners (LRMP): options for development. Available at: <http://www.gmc-uk.org/about/research/26683.asp> (accessed July 2016).

We apologise to Dr C. Albert Yeung for this error and for the inconvenience caused.

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