Please note that all letters must be typed. Priority will be given to those that are less than 500 words long. All authors must sign the letter, which may be shortened or edited for reasons of space or clarity. All letters received are acknowledged.

Specialist lists

Sir, — I am a dentist who seeks referrals for fixed and removable prosthodontics. I have recently gained MRD and expect to be put on the specialist list for prosthodontics. My Fellowship is in oral surgery and so I have been informed that I will be put on the specialist list for dental surgery. Some of my patients wished to have their implants placed under a general anaesthetic.

Unfortunately on approaching the local private hospitals run by Nuffield and BMI I was refused admitting rights on grounds that I was not an NHS consultant in a surgical speciality but just a plain GDP. I did get admitting rights with a private hospital that was attached to the local NHS hospital. The Nuffield group recently bought this hospital out and so I am now back at square one. I would be interested to hear from other GDPs who have been refused admitting rights and also any who have admitting rights with the above hospital groups.

If I can show that a precedent has already been set then other colleagues and I may be able to break this 'closed shop'. At the moment, as we now cannot do operations under general anaesthetics in the dental practice, I have to ask one of the local oral surgeons to place dental implants for me if the patient wishes to be put to sleep. I would also be interested in the views of the GDC as to the effectiveness of their 'specialist lists.'I can be contacted either via the Bulletin Board on the BDA web page or at my practice in Poole.

G. C. Browning
Poole

Xylotox labelling

Sir, — Are you aware that Astra are producing Xylotox 2% with new labelling. The cartridges now have black printing, and contain 1:80000 adrenaline. Unfortunately they no longer state this on the cartridge, nor that it contains lignocaine (but they feel it is necessary to write it on the cardboard box they come in!).

Cartridges frequently do not remain in the carton they come in as the blister packs will be distributed to different areas, e.g. A&E, the ward and out patients in a hospital setting and different surgeries within a dental practice.This unnecessary alteration is causing confusion as previously the adrenaline concentration has always been stated on the cartridge, and serves a useful reminder to the operator as to what is being injected into a possibly medically compromised patient. Xylotox cartridge labels have been printed in red, green and now black, with reduced information. I have contacted Astra and they assure me that the formulation has not changed, unfortunately I believe

M. G. Perini
Preston

CPD learning

Sir, — The General Dental Council has recently published its expectations with regard to hours spent in professional development.[1] Are these really sufficient to maintain a professional edge when it is known that biomedical knowledge doubles every 20 years?[2] Are the traditional methods that will be utilised by and large to update knowledge and skills pertinent to dental practice in the year 2000? The essential need from a general dental practice standpoint and of course, that of other modalities, is that any system that purports to increase the knowledge base will also help to apply and deliver this to clinical decisions and practice. Will the methods used to fulfil the requirements of reaccreditation and recertification be as effective in this respect as they need to be?

It has long been known for instance that professionally derived information packs of literature on specific topics intended to increase understanding and knowledge about certain procedures, techniques or management often have little effect. A follow-up study of such a detailed information package sent over 14 weeks to Canadian doctors failed to influence treatment decisions and practice at all. The best determinant and predictor of such practice actions and decisions was the year of qualification.[3] Does this therefore indicate that in medicine, and perhaps also in dentistry, standards and skills in professional practice tend to stagnate and become frozen immediately the doctor/dentist completes formal training? Clinicians need solutions to be most effectively applied at the time clinical problems occur, or at least very soon after. What should be a reasonable time commitment to seeking the solutions to problems that have been logged as having arisen during patient management, in order to learn from these and modify future behaviour? Wyatt has suggested that five to 10 per cent of professional life should be so allocated.[4] The GDC and Royal Colleges, however, require some 50 hours per year with a proportion of this requirement difficult to mentor or monitor. This is less than one hour a week in toto, leaving a deficiency of anything from two to four hours a week from what is suggested and which seems eminently reasonable to me. Time pressure of course is a significant feature in seeking the solutions and knowledge we need to supply this educational impetus when required.

The priorities for such information can vary from solutions needed at the time to guide a particular decision or action, through solutions needed before seeing the next patient with a similar problem, to the solutions that may interest us but have no active clinical implications in our practice. Under pressure, it is usually only the first category that is addressed. There are many such questions that need consideration with regard to the overall process and no doubt the GDC proposals are a beginning. This is especially so in a profession such as ours that has hugely varied levels of CPD among those who belong, with some having no commitment at all, but nevertheless considering they can 'get by.' Evolution and culture change will perhaps be difficult in many areas, and it will no doubt be too much to hope for explicit funding in future years from any third party, including the Government, for the next rung on the educational ladder. Notwithstanding this, the opportunities presented by the GDC proposals — clinical governance, the inevitable expansion of formalised workplace based training in primary dental care and, most importantly, an eventual structured career pathway for GDP dentistry — are hopefully not too far away and will help to facilitate the process.

K. F. Marshall
Oxted

1 Lifelong Learning, taking dentistry forward, General Dental Council, 2000, London
2 Wyatt, J C, Use and sources of medical knowledge. *Lancet* 1991; **338**: 1368-1373
3 Evans C E, Haynes R B, Birkett N J, *et al*. Does a mailed continuing education package improve physician performance? Results of a random trial. *JAMA* 1986; **226**: 501-504.
4 Wyatt, J C, Keeping up: continuing education or lifelong learning? *J R Soc Med* 2000; **93**: 369-372.

Timings Inquiry

Sir, — I can appreciate the time and effort that has gone into the Heathrow Timings Inquiry (*Br Dent J*, **188**: 4) and Dr. Kravitz's reply to my comments (*Br Dent J*, **188**: 11). However, I feel that we are in times where the medical and dental professions are very much under surveillance and our procedures and treatments need to be beyond question, based on sound principles and research. An important project such as the Timings Inquiry needed more than an anec-

dotal assessment of the various treatment scenarios. Perhaps a specialist independent organisation on the lines of MORI should have been used to poll those working in the GDS, using data on treatment pattern profiles from the Dental Practice Board. Two scenarios could have been put: the times for the present treatment compromises dictated by inadequate GDS funding; and one for a more confirmed treatment protocol in line with current UK teaching such as I suggested for root canal treatment, for example. The DDRB could have been presented with a more realistic view of the problems of dental practice within the Health Service.

I am particularly interested in endodontic treatment and I am aware of the financial frustrations of carrying it out within the GDS, which I do regularly. In my letter, I highlighted the endodontic case but the whole of dental care within the GDS needs thorough re-evaluation based on clinically acceptable protocols. This would provide a sound basis for GDS payments.

The profession is at the crossroads of quality of care and quantity of treatment to be provided. Standards and quality are issues for everyone involved and the moment we separate them from the pay structure we will be lost. Until these matters are firmly addressed we will continue in a crippled state struggling with compromise. I felt the Timings Inquiry was more of the same and an opportunity had been missed to address these problems we face today as we try to provide our patients with an acceptable level of care.

S. Day
Gosport

Drinking to excess?

Sir, — Now that drinking has been shown to be probably an even greater risk than smoking in the aetiology of oral cancer[1], should the BDA still be giving its accreditation to mouthwashes that contain alcohol, often in considerable concentrations?

D H Silver
Sheffield

1. Hindle I, Downer M C, Speight P M. The association between intra-oral cancer and surrogate markers of smoking and alcohol consumption. *Community Dental Health* 2000; 17: 107-113.

The BDA's Education and Science Department respond:

Following reports over the years suggesting a possible association between mouthrinse use and oral cancer, the US Food and Drug Administration in 1996 (Food and Drug Administration: Dental Products Panel, OTC Plaque Products Subcommittee, condensed transcript and concordance, Washington, 1996) conducted an extensive review of the available evidence. The FDA concluded that there was no evidence that mouthrinse use increased the risk of oral cancer and confirmed the safety of these products. While excessive ingestion of alcoholic beverages can produce systemic effects, this is quite different from the short topical exposure to mouthrinses which occurs during rinsing and expectoration. To be accredited by the BDA, a product must demonstrate both safety and effectiveness. While lower alcohol levels are to be preferred, other things being equal, a reduction in alcohol content would significantly reduce the efficacy of certain products.

Cycling capers

Sir, — Dentistry is not a job requiring much physical exertion. I do quite a lot of cycling to keep fit by way of compensation. I also tend to cycle on short trips around home, e.g. trips to the shops and to visit friends. While not being any kind of 'eco-warrior', I do like to think that I do a little towards using my car less and helping the environment. Thus, the letter from G.Balfry (*Br Dent J* 2000; **189**: 126) caught my eye. I hope that there was either a typing error or the letter was written ironically, as a mileage allowance of 0.062p per mile is not going to encourage even me to cycle to postgraduate meetings.

A typical round distance to a meeting for me is around 20 miles. For which I would be entitled to a grand sum of 1.24p — rather less than the cost of the stamp to send the claim to the local health authority. Even if there was a typographical error and the amount should have read £0.062 per mile, I would still receive only £1.24 for the effort of cycling to a meeting (as opposed to £4.60 if I travelled by car). This derisory amount is not going to convert anyone from going by car to going by bike and thus is a waste of administrative resources and serves only as an excuse for the local health authority to claim to be 'cycle aware' or 'green'. If the health authority truly wishes to encourage cycling, it should provide positive incentives, i.e. pay more per mile to cyclists than motorists.

P. A. Whitehead
Leeds

Antibiotic use

Sir, — I was not surprised at the outcome of the study of 'Prophylactic Antibiotic Prescribing in the NHS General Dental Practice in England' (*Br Dent J 2000; **189**: 43)*. There is general confusion in the use of antibiotics amongst our profession, and amongst orthopaedic surgeons. The speaker at a recent course on 'Dental Treatment of the Medically Compromised Patient', advised us GDPs to write to orthopaedic surgeons for advice on whether their patients with prosthetic joints required ABC for dental treatment. He added that there was no evidence to support this use, but medico-legally we would be in a better position if we had done so. I duly contacted the surgeon of a patient with a hip replacement who required an extraction. He advised antibiotics 'two days prior to treatment, followed by at least one week following. Any broad spectrum antibiotic is suitable.'

The study has shown that there is a clear need for simple straight-forward, easy to read instructions. May I suggest a handout be printed and sent to each GDP and orthopaedic surgeon in the country. That way we will all know where we stand, and antibiotic over-use will be reduced.

A. J. Foxall
Colwyn Bay

Sign of the times

Sir, — I read with great interest the recent article by Champion and Holt (*Br Dent J* 2000; **189**: 155) about dental care for children and young people who have a hearing impediment.

Having recently graduated and embarked on a career in the community dental service, I was encouraged by colleagues to learn sign language. I find sign language to be a wonderful form of communication. Not only have I improved my communication with hearing impaired patients, I believe sign has also helped me communicate better with the hearing ones. Communicating in sign is not only about hand gestures, it is very much about descriptive facial expressions and open body language.

I would highly recommend learning sign not only to dentists, but other members of practice teams whether they are nurses or receptionists. Admittedly, it is not used everyday, but as I have pointed out, it can be very beneficial in general communication. Interested people should find out about local education classes, or contact the Council for the Advancement of Communication with Deaf People (CACDP), based at the University of Durham.

T. S. Badh
Derby

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