Send your letters to the Editor, British Dental Journal, 64 Wimpole Street, London W1G 8YS E-mail bdj@bda.org
Priority will be given to letters less than 500 words long. Authors must sign the letter, which may be edited for reasons of space.

Universal brotherhood

Sir, I write in response to the letter *Volunteer programme* (*BDJ* 2006; **201:** 617) to offer suggestions for volunteer programmes such as Bridge2Aid. These programmes require resources in the form of work force which can only be provided by professionals, in this case, by dentists and auxiliaries. While Bridge2Aid, for example, has a basic requirement for dentists with two years' postgraduate experience, a practitioner with this requirement will quite likely have to take leave from practice or his/her job and may suffer financial loss. Slight modifications of such rules may not only bring in a larger number of dentists, but also be of use to them in refining their skills.

In India, postgraduate students in the specialty of Community Dentistry are trained in organising and conducting screening programmes for oral cancer and pre-malignant lesions and also in working in treatment camps in rural areas in association with various government and non-government organisations. These programmes follow all universal precautions of infection control and provide quality treatment within the available resources. 'Standing dentistry' is practised at these programmes. If required, referrals are made to teaching hospitals where these patients are treated for free.

Dental treatment programmes in remote rural areas constitute a method in which social welfare organisations and dental schools cater to the needs of poor rural people.[1] These students can exercise and enhance their skills in providing dental treatment in other countries like Tanzania. Such schemes can be made into twinning programmes incorporated in the postgraduate curriculum and not only increase oral health care delivery in the respective countries but also increase a feeling of universal brotherhood among the dental professionals of different countries.

N. Bali
Manipal

1. Auluck A. Oral health of poor people in rural areas of developing countries. *J Can Dent Assoc* 2005; **71:** 753-755.

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Dispassionate assessment

Sir, *Written off* (*BDJ* 2006; **201:** 497) was a plea to UKAP for 'a scientific assessment of the risks, without any emotional or political considerations'. Lady Winifred Tumim and Professor Jeremy Bagg responded on behalf of UKAP (*BDJ* 2006; **201:** 740) with plenty of science quoted to explain their perpetuation of the existing guidance. But how dispassionate are they in their assessment of the potential risk posed by an HIV infected dentist?

They say, *'recommended standards of cross infection control for the dental profession have been strengthened significantly since HIV was first described. However, these standards are not universally implemented'*. Apart from being an indictment of British dentistry, if this statement is correct about the transmission of HIV, it would also apply to hepatitis B and C which are far more easily transmitted; but we are not seeing clustered outbreaks of hepatitis (B or C) associated with UK dental surgeries – and have not done so since HIV was first discovered. The facts don't support what UKAP implies in this statement: *'Without very close monitoring, a missed dose could result in a transient increase in viral load. Following a precautionary principle, it was recommended that those whose viral load was suppressed on therapy should not be allowed to resume unrestricted practice.'*

This hypothetical conceit is insulting to the healthcare workers involved. If anti-retroviral therapy is stopped, the immune system suffers and the patient feels ill, sometimes very ill. There is also the possibility that the retrovirus will develop resistance to the medication. Two simple reasons why people living with HIV are extremely well motivated to take their medications regularly. If necessary a simple check could be instituted (perhaps by another member of the dental team) before the dentist starts work for the day, but UKAP doesn't seem to be interested in resolving the problems for the affected dentist.

A cynic might consider that this letter was motivated more by politics than a concern for the dentists who are being written off. It certainly doesn't encourage one to think that the scientific evidence is being assessed unemotionally or that UKAP cares about the dentists whose careers are destroyed as a result of their guidance.

D. Croser
By email

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Preventing a dropout

Sir, I read with great interest the article *Academic dentistry – where is everybody?* (*BDJ* 2006; **200:** 73-74). It is understandable that new graduates may not opt for an academic career due to the financial burden of repayment of loans, especially when private practice is usually more rewarding financially, in developing countries like India as well as in developed countries.

Recruitment of potential immigrant dentists for academic positions at UK universities may be a feasible idea for alleviating the academic fallout. However, foreign trained dentists from developing countries are unable to fill academic positions in the UK due to the facts that the General Dental Council does not recognise their previous academic and professional training and also because dentists from the European Union are preferred. Dentists who are solely interested in academic teaching posts should be waived the International Qualifying Exam. Grants provided for overseas researchers who are from developing countries are very few and most universities ask students to obtain funding from their home country or the local embassies. Distribution of grants from individual universities would help in retaining new found talent.

I do feel that UK universities could start collaborative programmes in the developing world and harness the talent among aspirants who could be recruited for academic positions in the UK. A unique example of this is represented by the Universities of Bergen and Oslo, Norway which have developed collaborative programmes for students from developing countries under the

quota stipend scheme. Another option could be the opening of satellite branches of UK universities in developing countries so that the pattern of education provided is uniform. These dentists could be later recruited for academic positions in the UK thereby preventing a dropout of dentists from the academic field.

M. Bhat
Manipal
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Aware of the debate

Sir, we would like to respond to the recent request from P. Woodhouse for advice about antibiotic cover (*Left out to dry BDJ* 2006; **201:** 741). The BDA advises members to follow guidance given in the BNF when considering antibiotic prophylaxis for patients with joint replacements, drug/radiation induced immunosuppression or conditions like systemic lupus erythematosus. BNF 52 (Section 5.1 Antibacterial drugs - Table 2. Summary of antibacterial prophylaxis) states that *'patients with prosthetic joint implants (including total hip replacements) do not require antibiotic prophylaxis for dental treatment'* and that *'patients who are immunosuppressed (including transplant patients) and patients with indwelling intraperitoneal catheters do not require antibiotic prophylaxis for dental treatment provided there is no other indication for prophylaxis'*. Patients with systemic lupus erythematosus who do not have endocardial disease do not routinely need antibiotic prophylaxis. From a dento-legal perspective, Dental Protection recognises that clinicians face an unsatisfactory period of uncertainty where different guidelines exist simultaneously. It advises that dentists should be aware of the debate and keep abreast of developments to ensure that appropriate guidance is followed.

S. Carruthers
Chair, BDA Dental Advisory Group to the BNF
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Aesthetic confusion

Sir, there appears to be confusion about the use of the aesthetic component of IOTN which of course has recently become more important with respect to the prioritisation of NHS orthodontic treatment. Whilst examining for the intercollegiate M.Orth exam in London last summer I was informed by one candidate that 'It is not up to me to award the IOTN aesthetic component grade, this is the patient's job'. Having discussed this with some of my colleagues, it seems that this is a fairly widespread view and is apparently being taught as such in some units.

Whilst the aesthetic component is an invaluable tool for patient counselling with respect to treatment need, it is NOT correct for the patient to award the grade. This must be done by an appropriately trained dental professional. If it were the patient's job than obviously any 'informed' parent or patient would be able to qualify for treatment regardless of the malocclusion!

N. Fox
By email
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Indemnity in Australia

Sir, I am unsure if many British dentists are aware of the current medical indemnity issues surrounding dentists that work in Australia.

From early 2004, the Australian federal government changed medical indemnity laws, ultimately changing the entire dental/medical indemnity policies in this country.

After early 2004 dentists who have worked in Australia for even a brief period will need to continue to pay 'the tail' of medical indemnity insurance to protect them from possible litigation for a period of up to six years, after they stop working in Australia.

Medical indemnity insurance for dentists can be expensive in Australia. A locum in Australia for even a short period of time, say three to four weeks, would also need to pay this six year tail cover to protect themselves medico-legally.

To make matters more difficult the actual amount to be paid upon cessation of work in Australia cannot be advised, and is at a reduced full year's premium for this six year period.

Australia is a beautiful, diverse and friendly place to work as a dentist. However, I urge all dentists considering working in Australia to contact Australian medical indemnity companies to consider these implications before working there.

B. Duane
By email
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