offered to those whose journey has been inconvenienced by even a few hours.

For reasons best known to the DH it has taken almost 16 months for it to respond to a public consultation (December 2011) that was already late in recognising advances in the management of patients. Regardless of the consensus view of the expert panels advising the UK Government, the Beijing Declaration of 2009[1,2] had already highlighted a potential breach of human rights caused by a failure to review matters.

It is good news that dental colleagues living with HIV will now be able to return to work but would it not be reasonable for them to be compensated in some way for the delay, ie the period of time during which their ability to work had been unnecessarily curtailed?

Compensation for lost earnings might be difficult, but a practical offer of financial support for any 'back-to-work' training that might be required and a fast-track process to ensure that any previous NHS performer's number was restored, could well be possible. It is not uncommon for it to take six months to re-establish a performer's number.

Delays do happen, but by assisting those who have been inconvenienced by the extended process adopted by the DH would go some way towards demonstrating the Chief Medical Officer's original declared intention for the consultation back in 2011: *'achieving a fair balance between patient safety and the rights and responsibilities of healthcare workers with HIV'*.[3]

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WORRYING ATTITUDES

Sir, we read with great interest the recent article *Obesity, diabetes and periodontitis – a triangular relationship* (*BDJ* 2013; **215:** 35-39), and in particular the suggestions that 'dentists should be more proactive in working with medical colleagues in diagnosing and managing diabetic patients ... dentists have the opportunity to identify unrecognised diabetes and pre-diabetes in their patients and refer them to a physician for further evaluation and care'.

Last year we established an extensive multi-disciplinary team of consultant dental clinicians and endocrinologists, primary dental and medical practitioners and research methodologists who all share an interest in oral health and medical conditions such as diabetes and obesity. After successfully completing initial pilot work in collaboration with the diabetes and primary care research networks, we have made no fewer than five applications for research funding, to both national and international organisations, to study a novel approach for risk-assessment for diabetes and pre-diabetes in the dental setting. None of these applications has been successful. Of particular note was the disappointing feedback recently received following one application to a large UK charity: 'The committee also questioned how keen GPs would be to deal with referrals resulting from this screening'.

Prevailing attitudes such as this are worrying and indeed suggest it may prove difficult to secure the evidence required to change clinical practice in the UK, including financial aspects, and encourage dental professionals to help identify at risk patients, particularly those with pre-diabetes, and refer in a timely manner for appropriate care.

If these fairly straightforward procedures can be implemented within the dental setting, the more serious implications of full diabetes may be obviated, thereby improving patients' quality of life and helping reduce the high cost of both treating and managing the serious complications of this condition, including its oral manifestations.

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