pandemic influenza policies, there have been calls to exclude experts with commercial ties from major public health policy decisions.[8] Cancer Council Australia does not accept funding from the pharmaceutical industry, in part because of the organisation's role in guideline development. The Council also funds the patient group Cancer Voices, which ensures there is a patient advocacy group that is not reliant on industry funding.

Some authors argue that encouraging greater transparency is the wrong solution, and is comparable to asking doctors in the 1800s to declare whether they washed their hands between doing autopsies and delivering babies.[9] They cite the limited evidence[10] that is available, suggesting there is potential for perverse consequences, such as encouraging unwarranted trust in biased advice. A better solution, they argue, is to end the financial entanglements between industry, research and practice.

However, it is likely that such entanglements will continue into the foreseeable future. In the meantime, Australian clinicians, researchers and related organisations and institutions are likely to come under increasing pressure to provide full and open public disclosure of financial and other ties with commercial interests. It would be helpful if efforts to promote open disclosure were carefully evaluated to establish their impact on a range of areas, including the attitudes and behaviours of patients, clinicians, researchers and other relevant parties.

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Further reading

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Melissa Sweet has an honorary position as a chief investigator on a National Health and Medical Research Council-funded project 'Calling the tune? Investigating corporate influences on media reporting of health'. She maintains the Crikey Register of Influence.

Letters

The Editorial Executive Committee welcomes letters, which should be less than 250 words. Before a decision to publish is made, letters which refer to a published article may be sent to the author for a response. Any letter may be sent to an expert for comment. Letters are usually published together with their responses or comments in the same issue. The Editorial Executive Committee screens out discourteous, inaccurate or libellous statements and sub-edits letters before publication. The Committee's decision on publication is final.

Multiresistant organisms at the front line

Editor, – I read the dental note (Aust Prescr 2010;33:71) about not using amoxycillin as the first drug of choice for oral infection to reduce the prevalence of multiresistant bacteria, for example life-threatening *Streptococcus pneumoniae*.

I am a dentist and we have always been told that amoxycillin is the best and safest antimicrobial when encountering oral infection. So what will be the next best thing?

Shahriar Sanati
Dentist, Sydney

Associate Professor Michael McCullough, Chair, Therapeutics Committee, Australian Dental Association, comments:

Dentists were once told that amoxycillin was the best and safest antibiotic for most dental infections. However, this idea has been considerably challenged over the past several decades leading to the current concept that penicillin is the best choice as first option. These concepts are clearly outlined in the Therapeutic Guidelines: Oral and Dental. Unfortunately, there is likely not going to be a 'next best thing', so we need to use our currently available antibiotics judiciously.