COMMENT

Letters to the editor

Send your letters to the Editor, *British Dental Journal,* 64 Wimpole Street, London, W1G 8YS. Email 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.

OMFS

Out of hours provision

Sir, I left NHS physiotherapy feeling that the tightening of the NHS purse strings was reducing quality. Physiotherapists who left were not replaced and senior physiotherapists were compelled to attend competitive interviews for their own jobs. Those who were unsuccessful were downgraded, many of whom subsequently left. The loss of these highly skilled and experienced staff resulted in a flattened Christmas tree model, with a reduced number of seniors providing expert patient care and training and support for juniors.

Now eight years on, I find myself with similar concerns as a dental core trainee (DCT) working within a busy maxillofacial unit. Historically, there would be a DCT providing specialist input with back up from a specialist registrar and consultant 24 hours a day. Now many hospitals have transitioned to an SOS doctor at night system where a number of surgical specialisms are covered by one surgical foundation year two doctor, often with limited maxillofacial training.

The aim of this is to cut costs, improve patient safety and to reduce out of hours service work to allow better, focused training during the day. However, one must guard against unnecessary admissions, reduced quality and access to care. The change creates the potential for patients being admitted unnecessarily and experiencing delays in treatment. For example, a laceration, which could be dealt with overnight and discharged, might be admitted awaiting specialist input or a patient with facial fractures not requiring immediate specialist assessment or surgical intervention might similarly be admitted overnight and may even be transferred from other hospitals unnecessarily.

This issue is likely to be intensified with the new junior doctor contracts where working hours are monitored and enforced with such vigour that training opportunities may be missed. For example, if the on-call DCT receives a referral for a patient in need of urgent dental treatment just before handing over to the medical SOS doctor, the current system does not allow the DCT to stay to provide this treatment. There is therefore a dichotomy in professional obligations. The responsibility one feels for the patient is trumped by the responsibility to honour the (ironically) educationally driven contract.

Not only could the recent changes result in reduced quality of care for patients, I believe they promote a lack of personal responsibility and dedication in trainees since these characteristics are not rewarded by the system. It is my opinion that returning to 24 hour DCT cover would benefit the trainees in terms of their experience and most importantly the patients in that they would be able to access specialist input in a timely manner. Although well-meaning, the SOS system and the junior doctor contract, as applied to DCTs, restricts learning opportunities and reduces access to specialist services. Emergencies occur out of hours; patients require treatment out of hours; and trainees can gain much experience out of hours.

N. Kanoun, by email

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Medical emergencies

Maths and methodology mix-up

Sir, the article *A ten year experience of medical emergencies at Birmingham Dental Hospital* (*BDJ* 2018; **224:** 89–91) made interesting reading but it appears the authors have got their maths and methodology completely wrong.

In the 'results' paragraph the authors explain 24 out of 119 cases were excluded from the analysis, because of missing information, leaving 95 cases. This seems to be supported by Figure 1 (bar chart with in total 95 people). Why then, in the results and summary, do they include these 24 cases again and use 119 as the denominator? You cannot exclude cases from analysis and then include them again in the denominator in your results and summary. But why are six cases with 'not enough information' included still, according to Table 1? Why were those not excluded as well? The total frequency of medical emergencies in Table 1 adds up to 115. Therefore, it appears another four were excluded (119 – 4 = 115). The authors state that in four instances there were multiple medical emergencies. So, 91 cases had one emergency only, leaving four cases with on average six simultaneous medical emergencies each (91 + 24 = 115)? That would have been very bad luck for these four individuals!

Even allowing for the basic error (re-including excluded cases) the figures in the results and summary are wrong. The authors are giving the impression 119 is the denominator. Cross referencing with the data in Table 1, it is hard to follow how the authors come to the percentages stated in the summary unless, at times, they use 115 as the denominator but not all the time.

For example, asthmatic attack occurred three times. The authors state this is 2.6%. As a percentage of 95 that is 3.2%, as a percentage of 119 this would be 2.5%, as a percentage of 115 this would be 2.6%. Vasovagal syncope occurred (according to Table 1) 42 times. If divided by 119 this would be 35%, not 36.5%. It appears 115 was used as the denominator here (42 being 36.5% of 115). They continue: 'cardiac arrest, stroke and iatrogenic events 1.7%'. Do they mean 1.7% *each*? Myocardial infarction occurred once (1/119) × 100% = 0.84%. Unless the authors used 115 again as denominator, then it would make sense (0.86% rounded up to 0.9%). But then why use 119 as the

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