Dental education

ADEE independent review

Sir, I write as a member of the Association for Dental Education in Europe (ADEE) project team, whose work was referred to in Shaun Sellars' recent article.¹ As both a member of the team doing the research and a practising dentist, I am very grateful to the author for highlighting our vital review of professionalism. I agree with the vast majority of what Mr Sellars says, not least the argument put forward in the final paragraph, that for 'right touch' regulation, 'we need to understand what society as a whole, and not ourselves as individuals, deems to be appropriate. The only way to do this is to collect the information from dental professionals and the wider community'.

It is important, though, for us to correct a factual inaccuracy contained within the article. Mr Sellars states that 'the GDC, in conjunction with Cardiff University, conducted a survey into professionalism in dentistry' and his final paragraph begins 'It could be argued that the GDC are not the right people to conduct this research'. I know that the GDC would agree with this argument, as indeed this is the very reason they commissioned the ADEE, as specialists in the field, to undertake the research independently.

Having successfully responded to the GDC's competitive tendering process, the ADEE conducted an extensive review of 'professionalism'. This four-part review included: a rapid evidence assessment of the global literature relating to dentistry and wider allied healthcare professions; scoping interviews with topic experts; focus groups with dentists, DCPs and members of the public; and a modified Delphi process (the 'survey' to which the author refers). The two-round Delphi survey was piloted with dental professionals and members of the public and had over 1,000 responses to round one and almost 700 to round two.

As Mr Sellars refers to in his article, there appeared at the time to be misunderstanding amongst some members of the profession about the motivation behind the survey, despite our inclusion of an introduction explaining the rationale and methodology of the research. I hope this clarification of the facts and the subsequent publication of the full review will alleviate any potential concerns.

The review is complete and due for publication in the near future. I am confident that it will prove to be an interesting read, and hope that further discussion will be generated on this vitally important subject.

J. Cowpe, Cardiff, UK

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<https://doi.org/10.1038/s41415-020-1738-9>

Antibacterial resistance

Start smart then focus

Sir, the second audit of antimicrobial prescribing in secondary care has recently closed: a collaboration between the Association of Clinical Oral Microbiologists (ACOM), Association of Dental Hospitals (ADH) and the English Surveillance Programme for Antimicrobial Utilisation and Resistance (ESPAUR). The month-long audit looked to build on the data collected in 2018 focusing on the therapeutic and prophylactic prescription practices in dental hospitals across the country. The importance of accuracy in appropriate prescription, in line with national guidance, and utilisation of the 'start smart then focus' protocol within our role as antimicrobial stewards cannot be understated. The Government's Antimicrobial Resistance Inquiry reports that antimicrobial resistant infections may claim tens of millions of lives per year, globally by 2050 if urgent action is not taken. Despite the data published by ESPAUR in 2018 showing a 25% reduction in antibiotic prescriptions by dentists, as a profession we are still responsible for 5.7% of all antibiotic prescriptions. Given the sizeable contribution to total antibiotic prescriptions that we as a profession are responsible for, we strongly urge practitioners in primary care to engage with the excellent toolkits and self-audit tools already published by Public Health England, Health Education and Improvement Wales and the Scottish Antimicrobial Prescribing Group.

Our collective efforts to ensure appropriate utilisation of antimicrobials to treat and prevent true infection, will help to protect the efficacy of existing treatments and buy the time required to develop new antibiotics and novel methods of treating infection.

R. Devine, Cardiff, UK

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The history of dentistry

The Royal Dental Hospital

Sir, may I, through your letter column, appeal to all ex-Royal Dental Hospital students and staff for support in an approach to Westminster Council for a Green Plaque to be placed on the outside of 32 Leicester Square, now a hotel, to commemorate the site of our Hospital from 1901 until its closure in 1985.

Some of you have already enthusiastically embraced this idea, but we would like the plaque to be 'owned' by as many ex-Royals as possible. For all of you with memories of the Royal and who wish our hospital to be recognised for what it stood for please send your details: name, email and years at the Royal, to brianwilliams14@btinternet.com. By so doing, you agree to be contacted by us for support in seeking approval from Westminster Council for a plaque. The greater our number the more likelihood of success.

The Royal Dental Hospital of London deserves recognition, not oblivion. It is up to all of us to ensure this doesn't happen. So please don't delay, email now. Thank you.

B. Williams, London, UK

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Ethics and law

Consensus, consent and DELPHI

Sir, to achieve safe and effective dental care, there is a legal expectation that a competent practitioner obtains and maintains consent while keeping good clinical records.¹ The Faculty of General Dental Practice (FGDP) has for two decades consistently developed three editions of their guideline: *Clinical Examination and Record Keeping* (CERK) acclaimed by independent experts to be of an excellent standard and widely recognised as a valuable dental resource.²

From 1 April 2020, the Department of Health and Social Care will implement a mandatory Systematised Nomenclature of Medicine Clinical Terms (SNOMED-CT) for NHS England dental practices. To achieve that aim an appointed Clinical Reference Group (CRG) used Delphi, a qualitatively ranked research protocol, circulating questionnaires to panels in four rounds until agreeing the items for inclusion in dental records.^{1,2} The CRG, its members taken from the GDC, NHSE and the FGDP, sought not to reinvent CERK, but to test its wider applicability, building on it, attaining

their consensus for dental records, then recommended:

A. Four rankings for items that are: Essential, Aspirational, Conditional or Not-Required

B. Three types of dental appointment: New, Recall and Urgent

C. Two purposes for the NHS workforce: Maintenance and Improvement...but... strikingly:

D. One great absence (that feels like a presence)... the word 'consent' doesn't appear. Concerns have been published that relegating a patient's anxiety from the essential to merely aspirational, hinders patient care and this is at odds with GDC standards that demand an approach that is holistic, appropriate and individual to each patient.³

Clinical communication influences how information is understood, remembered and evaluated, with patients and dentists influenced by the way in which information is presented and recorded. Anxious patients are frequently unclear about the facts of their treatment and the risk of the framing effect becomes real should a nervous patient's anxiety be relegated, failing to be recognised and understood as essential.⁴ Such a paradigm may vitiate the established and excellent CERK standards while confounding the nuanced negotiation required for Montgomery Consent, as SNOMED-CT may appear not to afford the appropriate recognition to dental patients as autonomous decision makers.⁴

Despite such concerns, it is reassuring to note from the CRG research, that failing to follow what is considered essential does not imply records are inadequate.² That statement supports the FGDP CERK foreword that no practitioner should be censured for failing to meet the recommended guidelines and individual patients and circumstances must be considered on their own merits.⁵

One good turn deserves another, the GDC, NHS England and the FGDP can be reassured, following their use of Delphi, our use of **DELPHI** (and their framework) guides towards Montgomery consent as: **Dental Examinations List Pertinent Health Information!**

J. Laszlo, London, E. Mills, Truro, UK

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<https://doi.org/10.1038/s41415-020-1740-2>

Medical emergencies

ABCDE – what?

Sir, we are all aware of what those letters mean. They are constantly drilled into our healthcare professional brains, and we mumble them at the sight of a medical emergency. We have all sat in training sessions where we are asked to one by one name a step in the well-known basic life support (BLS) algorithm. But what was that first step 'check if it is safe to approach'? We often get through that one quickly, as we assume the meaning behind it is obvious.

On a Sunday afternoon, a middle-aged man who had fallen and sustained a head injury caught my attention. He was profusely bleeding from what appeared to be an arterial bleed from the scalp, mixing with the rain brought to us by Storm Dennis. I did what any healthcare professional would do in line with our duty of care. I promptly checked the man's surroundings for danger, approached him and found him responsive but non-verbal. This took me to the circulation (C) step of the BLS algorithm where I identified the bleeding point on his scalp, grabbed a handkerchief and applied targeted pressure to the pulsating artery. The bleeding completely stopped, however, an estimated 200 ml of his blood was covering my hands, arms and clothes in my attempt to control the haemorrhage by the time the ambulance arrived a few minutes later. The man was unkempt and intoxicated. He was taken to hospital whilst I was cleaning my hands and I lost track of his whereabouts.

On reflection, there was no information on this man's infection status. I believe my understanding of checking for danger prior to approaching is flawed. After a series of conversations and occupational health

checks, I realised that I had not examined myself for small cuts or open wounds prior to bathing myself in a stranger's blood ungloved. This led to many sleepless nights and countless minutes of staring at my nail cuticles wondering if I can get a glimpse of breach of skin barrier.

Learning points:

- Checking for safety of the scene also includes objects on the patient that may harm you, such as their blood – would I have done anything differently had I stopped to think? Probably not
- Keeping track of individuals following bodily fluid contact or exposure. Risk assessment is based on their infection status as well as your cover. If needed, follow them to where they are to receive definitive care and wait for consent to test their blood to be obtained if and when appropriate
- Familiarising yourself with the guidelines available online and how they can be applied to real life situations away from your usual structured protocols in hospitals and clinics. <https://www.resus.org.uk/resuscitation-guidelines/>.

M. Aljefri, Liverpool, UK

This letter was received before the current pandemic crisis.

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Live and let die

Sir, it is becoming increasingly more common for our patients to survive into older age and with comorbidities which may increase their risk of medical emergencies. Palliative patients are also becoming more common.¹

Since their inception in the 1970s, Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders have been used to provide immediate guidance to healthcare professionals on the best action to take (or not take) should a patient suffer cardiac arrest or die suddenly.² DNACPR orders do not preclude the patient from receiving first stage treatment in a medical emergency (such as aspirin for cardiac emergencies) but should the patient require CPR this would have to be avoided due to the patient's wishes.³ Alternatives to DNACPR orders used in the UK include treatment escalation plans (TEPs), Unwell and Potentially Deteriorating Patient Plan (UP), Deciding Right and Recommended Summary Plan for Emergency Care and Treatment (ReSPECT)