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.

Dental education

Outreach and clinical complexity

Sir, the recent paper by Donnell *et al.* highlighted the effect of a global pandemic on final year students, with their feelings of uncertainty about the future mirrored across the profession.[1] Although the questionnaire return rate represented 12% of subsequent dental foundation (DF) trainees in the 2020 cohort (perhaps due to them being 'questionnaired out'), there was a lot of highly relevant information for dental schools, DF programmes, deaneries and the wider profession.

As with similar preparedness papers,[2] feelings of lack of preparedness around carrying out complex procedures, such as molar endodontics and surgical extractions, was a key point and some sensible and practical suggestions were made on how this may be improved. The value of outreach programmes in preparing students for life beyond dental schools was emphasised:

'Students have consistently expressed their appreciation for learning in outreach and community settings; however, this should not overshadow the need to refine the more complex skills in which they feel least confident.

'As such, some suggest that the lack of preparedness of dental students for complex procedures is as a direct result of increasing periods of time spent at outreach which contributes to reduced experience in key areas of restorative dentistry and oral surgery.'

From my experience, these complex skills can be well-refined in outreach by specialists/consultants visiting such centres regularly and supporting students in carrying out such procedures in an environment very similar to that in which they may be expected to work on qualification. The two need not be mutually exclusive and benefit not only students, but patients too.

As highlighted by the authors, whilst DF training may be the perfect safety net, closer working between schools, DF training programmes, deaneries and the GDC will ensure a smooth transition to the workplace with hopefully less need for such a net, which serves the interest of all.[3] As far as I am aware, successful DF completion rates are comparable pre- and post-COVID which is reassuring to all stakeholders.

E. McColl, Plymouth, UK

References

1. Donnell C, Thomas L, Foley J. Mind the 'GAPP': a pre-graduation assessment of preparedness for practice amid a pandemic. *Br Dent J* 2022; **232:** 556–567.
2. Ray M, Milston A, Doherty P, Crean S. In their own words: investigating the preparedness of final year dental students in the UK for independent general dental practice. *Br Dent J* 2018; **225:** 340–349.
3. McColl E, Luker J. Transition to the workplace. *Br Dent J* 2022; **232:** 286–286.

https://doi.org/10.1038/s41415-022-4343-2

Pharmaceuticals

A good old INR test

Sir, I write regarding the recent article on managing direct oral anticoagulants (DOACs) (*BDJ* 2022; **232:** 547–554). This extremely relevant article gives invaluable additional advice to supplement the SDCEP recommendations and I would like to spotlight the challenges that these drugs pose in general dental practice.

As a downside to the trend for 'keeping teeth for life', we are seeing ever increasing numbers of older patients requiring extraction of often heavily restored and compromised teeth whilst presenting with failing health, polypharmacy and often DOACs. The figure in the article of 9.2% of patients needing to reattend post treatment for repeated application of local measures highlights the unpredictability of outcomes for extractions in this group.

In general practice we do not have the backup of haematology services to determine how we should approach the management of cases that we have concerns about and rely instead on contacting patients' consultant cardiologists or general medical practitioners (GMPs). My experience in these correspondences has been patchy to say the least. The consultants frequently require repeated chasing up to provide a verdict and the GMPs are often unable to offer constructive advice. I have recently been told by a GMP that a patient's DOAC should be stopped for a rather unspecific 'several days', whilst another, obviously annoyed medical colleague, replied that we dentists 'should have protocols for that'.

Medico-legally, the buck stops with us and the risk of the outcome of a prolonged bleed, or worse, a stroke from cessation of appropriate medication, does little to ease the stresses of frontline dentistry. I am beginning to get misty-eyed thinking of the halcyon days of warfarin and a good old INR test.

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Climate change

An appropriate voice?

Sir, I am surprised that the *BDJ* is an appropriate voice for a member of an overtly political group of urban terrorists, Extinction Rebellion (ER).[1] The views expressed are an incitement to take part in civil disobedience, a criminal offence and are not what I would expect this journal to publish.

Whilst we live in a democracy which allows freedom of speech, minority groups such as ER have a disproportionate voice. Its actions, hardly non-violent, disrupt the lives of many, are a cost to the public purse and do not endear the organisation to the majority of the public.

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Reference

1. Benson K. Dental Extinction Rebellion. *Br Dent J* 2022; **232:** 587.

https://doi.org/10.1038/s41415-022-4356-x