Letters to the Editor

Send your letters to the Editor,
British Dental Journal,
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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.

EMIGRATION TO SCOTLAND

Sir, despite being a unionist I feel the SNP's victory at the latest election might have at least one benefit to dentists, if independence is achieved. It is inconceivable that a Scottish GDC could possibly be more costly, inefficient and bureaucratic than the UK GDC. Advance bookings for emigration to Scotland are perhaps advised.

J. R. Drummond, Dundee

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TACTICAL WEAPONS

Sir, I want to share with the readers an interesting conversation I had with a child patient recently. It so happened that after I completed the treatment for the patient, he came up to me and stood behind me for a while, looking very curiously on to the computer screen on which I was writing the notes.

Then after a pause he abruptly asked me a blunt question, 'why do you have tactical nuclear weapons on your computer?' It was bit of a shocker, rather a question which can set alarm bells ringing in the head, for I didn't want to be associated with nuclear weapons.

On enquiring as to what the patient meant, he pointed to the radiograph icon on the computer; he said that he has this icon for the tactical nuclear weapons in his video game that he plays at home (Fig. 1).

On R4 dental software, the icon appears above the teeth where a digital radiograph exists.

Then on a further search on the Internet I realised that the same icon is placed on containers or weapons that contain radioactive material.

Nuclear weapons increasingly feature in children's magazines, films and games.

In the modern day world, children can outwit you and may know much more than one can imagine.

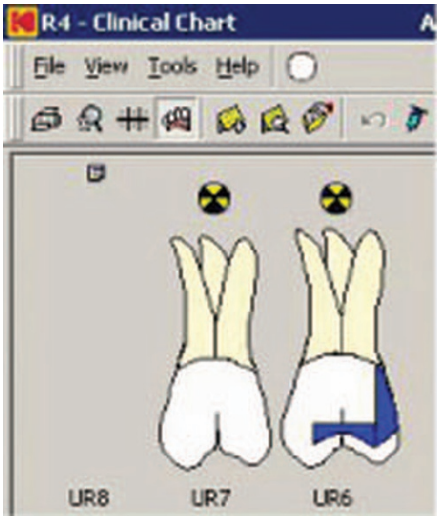

Fig. 1 The 'tactical nuclear weapons'

Z. Imran, Dundee

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NO STATISTICAL DIFFERENCE

Sir, I would like to draw the readers' attention to a very interesting article in the May issue of the *British Medical Journal*.[1] The study highlights a three-quarter drop in antibiotic prophylactic prescriptions, while showing no statistical difference in the incidence of infective endocarditis. I would hope this article provides some evidence for the difficult consultations we have all had with a small cohort of patients who are still insistent on having the prophylaxis.

Z. Esmail, London

1. Thornhill M H, Dayer M J, Forde J M *et al.* Impact of the NICE guideline recommending cessation of antibiotic prophylaxis for prevention of infective endocarditis: before and after study. *BMJ* 2011; **342:** 2392.

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FAILURE TO COMPLY

Sir, we would like to congratulate James Andrews for his recent article *CQC outcome for medicines management: an outsider's inside view*. In this paper, he highlighted a number of essential aspects of the CQC document *Essential standards of quality and safety*[1] that have received little attention in the dental press to date:

- Outcome 9H states that it is a practitioner's responsibility to ensure that medicines required for resuscitation or medical emergencies are easily accessible in tamper evident packaging[1]
- Outcome 11 is more concerned with equipment and training and states that 'all staff involved in using the equipment have the competency and skills needed and have appropriate training'.[1]

This equipment should be properly maintained, tested, serviced and renewed under a recorded programme. It should be stored safely and securely and where the service requires it this should be tamper proof.[1]

Although the CQC does not state what emergency drugs and items of emergency equipment practices should have access to, the information is already available in national guidelines produced by the Resuscitation Council (UK)[2] and accepted by the GDC. These were listed as the MINIMUM that was required.

We organise and deliver medical emergency training courses at a regional and local level. Although the national guidance was originally published in 2006, and revised in 2008,[2] it appears that there are still a number of practitioners who are either not aware of it or choose not to comply with it. This proportion of the profession seems

not to recognise that failure to comply with CQC guidelines could have severe implications both in terms of a civil case for negligence as well as leading to a withdrawal of CQC registration and/or disciplinary action by the GDC.

Emergency events are rare but they do occur and it is every professional's responsibility to ensure that they are adequately prepared with the correct drugs, but equally as important, the correct training so that emergencies can be recognised and managed at an early stage. Mr Andrews used an example where midazolam was inappropriately delivered in an emergency and led to aspiration: staff were inappropriately trained. This emphasises the importance of medical emergency training rather than training in basic life support alone. In our experience, the majority of professionals subscribe to basic life support training, which 'ticks the CPD box' but is of little use for the management of more common emergency events.

We propose that standardisation of medical emergency training in addition to standardisation of emergency drugs and equipment is required in primary dental care to optimise patient care should an emergency event occur and that CQC recommendations should be incorporated into medical emergency care in general dental practice.

K. H. Taylor, J. L. Burke
www.resuspod.com

1. Care Quality Commission. Guidance about compliance. Essential Standards of Quality and Safety. March 2010. http://www.cqc.org.uk/_db/_documents/Essential_standards_of_quality_and_safety_March_2010_FINAL.pdf
2. Resuscitation Council (UK). Medical Emergencies and Resuscitation – Standards for clinical practice and training for dental practitioners and dental care professionals in general dental practice. July 2006. Revised and updated June 2011. http://www.resus.org.uk/pages/medental.htm

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MORE EFFECTIVE GUIDELINES

Sir, it has been a decade since the introduction of the two-week urgent referral system for suspected oral cancer. Guidelines were developed to aid primary care clinicians in identifying potential malignancy, and thereby reduce delays in treatment in secondary care.

An audit carried out in the oral and maxillofacial department of QEII Hospital (East and North Herts NHS Trust) revealed that only 6% of urgent referrals were diagnosed with malignancy. Benign conditions such as mucoceles and lichen planus that should have been referred as routine were referred via the urgent pathway.

Previous studies have questioned the reliability of the guidelines, and suggested a need to revise them. An audit carried out by Hodgson *et al.*[1] revealed that dysplasia or malignancy was diagnosed in 7.4% of 241 patients. Singh and Warnakulasuriya[2] found a positive diagnosis in six out of 76 patients.

Low numbers of malignancy amongst urgent referrals will probably continue to occur with use of the current guidelines as they discriminate poorly between sinister and benign pathology. Furthermore, the urgent referral system could be used as a licence to refer anything that the primary care clinician is unsure of, however trivial it may be. Improved awareness of oral cancer and more effective guidelines are needed in the near future if the system is to be deemed efficient.

V. N. Mepani, J. A. Sherman

1. Hodgson T A, Buchanan J A G, Garg A, Ilyas S E, Porter S R. An audit of the UK national cancer referral guidelines for suspected oral mucosal malignancy. *Br Dent J* 2006; **201:** 643-647.
2. Singh P, Warnakulasuriya S. The two-week wait cancer initiative on oral cancer; the predictive value of urgent referrals to an oral medicine unit. *Br Dent J* 2006: **201:** 717-720.

DOI: 10.1038/sj.bdj.2011.581

FORMS AND FAILURE

Sir, the recent shocking BBC *Panorama* investigation on care home abuse highlighted the failure of the CQC to intervene despite three separate alerts from a care worker. Perhaps the CQC were concentrating instead on providing more forms for dentists to fill in? I for one am glad that the public will be able to rely on this organisation to censure us for getting our regulations confused with our compliances.

R. Bannister, Harrogate

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READ MY BLOG

Sir, in your editorial (*BDJ* 2011; **210:** 195) you encouraged dentists to contact the GDC in advance of the Council's meeting on 20 May to communicate the strength of feeling within the profession on the possible decision by the GDC to vote for a ban on dentists using the title 'Doctor'.

In order to allow sufficient time for the full impact analysis of the proposals to be undertaken, it has been decided that the issue will now be considered by the Council at its meeting on 22 September. Consequently we still have time to express our feelings on this matter to the Council and if we are complacent and do nothing we may wake up on 23 September to find we have lost our right to use of the title 'Doctor'. To help keep the debate alive I have started a blog at *keepcallingmedoctor.blogspot.com* and I would invite colleagues to visit and leave any comments they please.

There are two important issues for the Council to consider when deciding on how to vote on this matter. One is the impact a decision to implement a ban would have on the status of the profession, as dentists try to explain to their patients why they should no longer be called 'Doctor'. The second is the impact on the credibility of the Council if they implement a ban which they may find themselves unable to enforce.

M. Wilson
Esher

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APPLAUSE FOR NEW SCHEME

Sir, writing as a final year dental student attending Leeds Dental School I was very pleased to attend a symposium which outlined the new foundation year training scheme previously referred to as vocational training. The days where nepotism ruled the profession are seemingly long gone, with regard to initial job placement anyway. The new system puts a disproportionate amount of pressure on three 15 minute objective structured critical examinations, but this undergraduate believes this reflects the pressures that dental practitioners may be faced with on a daily basis. Being someone that has no family within the profession that can be relied upon, I applaud the new scheme and thank everyone involved in the restructuring.

C. Agyeman
Leeds

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