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.

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LETTERS

INEVITABLE DESKILLING

Sir, as a DF2 completing my first year as a maxfax SHO, I have been amazed at the simplicity of many dentoalveolar referrals the department receives. I acknowledge that the current system may not remunerate GDPs for lengthy surgical procedures but there now appears to be a *carte blanche* approach from many dentists seeking to avoid even the most straightforward of extractions.

I wonder whether this reluctance is due to educational shortcomings on the part of the nation's dental schools or whether the current UDA system simply cannot accommodate dentoalveolar surgery.

As a newly qualified dentist, I can appreciate the apprehension felt by many tackling surgery in their VT year, but I believe that this largely stems from a lack of appropriate, hands-on experience throughout current dental education. If, as a result, GDPs routinely refer the simplest extractions as surgical phobia takes hold, then deskilling must inevitably follow.

I am curious to know the views of your readership and whether they feel such patients should be seen by secondary care or whether the situation will generate a more significant role for the specialist oral surgeon.

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A YEAR WISER?

Sir, as medical emergency trainers we are exposed to differing environments in which training is mandatory (including primary care) and our experience tells us that many dental surgeries still fail to be compliant with CQC guidance which recommends that staff follow

the guidance of expert bodies. In the case of medical emergency management, these have been developed and produced by the Resuscitation Council (UK)¹ and approved by the GDC. In addition, we have found that some dental practices have adopted equipment and training that is focused on lowest cost rather than being truly compliant.

One practice reviewed by the CQC in North West England was highlighted as causing 'major concerns'² with six documented, one of which related to *Outcome 11: People should be safe from harm from unsafe or unsuitable equipment*, which was communicated to the Health and Safety Executive.

Concerns were also noted relating to *Outcome 4: Medical emergencies, care and welfare of people who use services*:

- *The kit did not contain any midazolam which is required in case of in the event of someone with epilepsy going into more than one fit*
- *There was no record of the oxygen cylinder being checked to ensure that the flow meter was in working order and there was a sufficient level of oxygen available in the event of an emergency*
- *There were no child size oxygen masks available*
- *The emergency kit was stored in a locked cupboard downstairs in a surgery that was rarely used. The location of the kit would cause a delay in treating anyone in an emergency*
- *The kit did not contain a blood sugar testing kit or non-latex gloves and scissors although not compulsory would be advisable*
- *The first aid kit was stored in the same cupboard amongst an array of other items and there was no clear signage as to where to find it*

- *There was no designated first aider and no staff had received first aid training.*

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The practice was closed for seven days following the receipt of the CQC report and had to respond indicating remedies to be taken. Following this period of time the CQC would confirm that these improvements had been made.

The need for effective compliance has been tragically highlighted by two relatively recent deaths in dental practice attributed to chlorhexidine allergy.² Although it is a generally held view within the profession that medical emergencies are very rare, evidence is beginning to emerge that suggests increased incidence. In a survey of German dental practitioners, 57% reported up to three emergencies and 36% reported up to ten emergencies within a 12-month period.³ There is no doubt that proper training and equipment substantially improves patient outcome.

'By law providers of certain adult social care and health care services have a responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect.' (Care Quality Commission, www.cqc.org.uk)

K. H. Taylor, J. L. Burke
www.resuspod.co.uk

1. 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 February 2012. www.resus.org.uk/pages/medental.htm.
2. Reissner D. Death at the dentist. *Dental Tubules* 20 May 2011. <http://www.dentaltubules.com/DavidReissner1>