Letters to the Editor

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LETTERS

DCP LDS

Sir, what should the future direction of dentistry be? Should we be more active in preventive activities? These are just two of the questions posed by M. V. B. Nelson (*BDJ* 2012; 212: 205–206).

It is undeniable that the profession should be looking at ways in which preventive dentistry can be enhanced. Dental hygienists are key players in this role. In most countries where they are trained, the hygienist course is at least three years. In the UK, the two-year training courses for hygienists have been severely curtailed. Whereas previously every dental school or hospital in the UK had a hygienist training course, now there are only five. The remainder have been replaced by combined hygienist/therapist courses of only 27 months (of which there are eight), or by three-year degree courses (a further eight). Only one school provides the therapy course as an 'add-on' for dental hygienists (data gathered from a recent analysis of websites of training establishments providing hygiene and therapy education, as listed by the GDC). DCPs are trained to perform a high proportion of the day-to-day procedures undertaken by dentists in general dental practice and it is a credit to the teachers and students that there have been, to my knowledge, no major criticisms of the abilities of those qualifying under the 27-month programmes. Nevertheless, are they the best way forward?

There is considerable demand for hygienists in general dental practice but there seems to be little demand for dental therapists. There is anecdotal evidence that many DCPs are having difficulty in gaining employment that uses their dental therapy skills and

they have to work solely as hygienists. Unless the demand for therapists increases, they are at risk of becoming deskilled in this aspect of their work and their training will be wasted. Also, are we discouraging potential applicants who are dedicated to prevention rather than to restorative dentistry?

With increasing deregulation in the health services and in other professions, perhaps it is not surprising that there is pressure from some DCPs that they be permitted to undertake independent practice. Should this be resisted?

In this rapidly changing environment a fresh look at manpower issues is needed, especially hygienist/therapist education. The following proposals could be a starting point for debate: an expansion of hygienist-only training using two- or three-year programmes (comparable to Europe, the USA and Canada); dental therapy training to be one- or two-year add-on courses to dental hygiene training. Only sufficient places to be available to meet the demonstrated demand and need for dental therapists.

Although most of us support the idea of a team approach to dentistry, if independent practice by DCPs does become a reality, then a three- to four-year course for a fully trained hygienist/therapist may be deemed to be acceptable.

In the middle of the last century, the LDS course (one year shorter than the BDS course) was phased out of universities. Perhaps 'LDS' should be resurrected as a registrable first qualification for the DCP graduates of these longer courses.

The profession must plan for the future, not drift into it.

D. G. Hillam, Tetbury

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AUTOMATON BEHAVIOUR

Sir, I write to offer my opinion on the case highlighted in the letter from J. Rowarth (*BDJ* 2012; 212: 259) based on the limited facts in the letter.

The decision to prosecute (ie bring a summary proceedings against the patient) was for the Crown Prosecution Service (CPS) to make. However, not all crimes will automatically be prosecuted. The CPS retains discretion to prosecute which should be exercised in accordance with published guidelines. The CPS must have been satisfied that there was enough evidence to provide a 'realistic prospect of conviction against' the patient (The Evidential Test) and that the prosecution was 'in the public interest' (The Public Interest Test).

We are not told with what offence the patient was charged but there is an alleged forgery [see Forgery and Counterfeiting Act 1981, section 1 – an offence triable either at the Magistrate Court (summarily), as in this case, or at the Crown Court (trial by jury)]. The general rule, expressed in the maxim, *actus non facit reum nisi mens sit rea*, is that an offence can be committed only where the criminal conduct is accompanied contemporaneously by some criminal fault – a guilty mind. The patient had received their treatment under IV sedation. It could therefore be argued that she altered the prescription whilst under the influence of the midazolam (intoxicant) in her system and not voluntarily; she also lacked the requisite guilty mind to defraud. In short the midazolam made her behave like an automaton!

Involuntary acts will not attract the sanction of the criminal law, hence a defendant who committed a prohibited act in a state of automatism will have a

defence. The patient had solid defence in law – a) non-insane automatism and b) involuntary intoxication. Based on the evidential test alone, I fail to see why the CPS decided to prosecute the patient. It is submitted the CPS failed to apply the test properly or at all. The CPS has covered itself but with glory.

Can any lesson be learnt from this case? It is my tried and tested practice that all postoperative instructions (both verbal and written) are always given to the accompanying responsible person (but never to the patient), emphasising that the patient may not remember very much for the rest of the day and therefore [s]he should not, among other actions, sign anything important.

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1. Quick [1973] Q.B. 910 C.A.

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RESIGNED TO PENSION LOGIC

Sir, as a female dentist, I am going to have to wait longer for my pensions than I originally expected and, with everyone else, will receive a lot less from my private pensions than originally predicted. This is not surprising as life expectancy has increased. In 1967 male life expectancy was 70.5 years, just over five years after the 65th birthday. In 2011 male life expectancy is 78, 13 years after the 65th birthday. We cannot expect the same percentage and number of years' pension contribution to fund our increased requirements.

Like many, I have medical conditions which prevent me from working full time, but I can work part-time and hopefully should be able to do so for a number of years to come. Pensions related to average earnings seem a sensible option, since more people may have to consider working part-time as we have to work longer.

Although not overjoyed with this prospect, I am resigned to its logic.

H. Butler, Dorset

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MANAGING ASPIRATION

Sir, a 68-year-old female presented to our A&E department with dyspnoea, a productive cough and intense chest pain on inspiration. She was diagnosed with

a left lower lobe pneumonia and pleural empyema, caused by aspiration of dental amalgam, which had occurred some months earlier.

Whilst in A&E, the patient had a hypoxic cardiac arrest which required two cycles of CPR and emergency drugs, along with intubation and ventilation, before her circulation returned. She was admitted to the ICU for continued mechanical ventilation and antibiotic therapy. A CT scan of her chest was performed once the patient's condition had stabilised (Figs 1-2).

The dental amalgam was removed with rigid bronchoscopy, however, if this had failed, then a thoracotomy and pulmonary lobectomy would have been necessary. She eventually made a full recovery.

Foreign body aspiration is a well recognised complication of routine dental care. A wide variety of aspirated foreign bodies have been reported from teeth and restorative materials to instruments.³ The probability of aspiration is increased by the patient lying in a supine position for dental treatment.

Patient groups that are at increased risk of aspiration include the elderly, complete denture wearers, sedated patients, patients with organic brain disease such as Parkinson's, and those with neurological disabilities.² These patients may have a decreased gag reflex, functional swallowing impairment or other abnormalities of the protective airway mechanism.^{1,2}

Common early signs of foreign body inhalation include coughing, choking, inspiratory stridor, paradoxical breathing, decreased oxygen saturation and cyanosis.² Early complications can lead to cardiac arrest and laryngeal oedema. Long term retention of a foreign body in the lung can lead to vocal cord paralysis, pneumonia, pneumothorax and death.²

The key to managing aspiration is of course prevention,¹ but in the emergent situation, the patient should be quickly put into the reverse Trendelenburg position² and encouraged to cough. If coughing fails to relieve the obstruction, then back slaps and abdominal thrusts must be performed. If this is not rapidly successful then the patient must be transferred to hospital. An asymptomatic

Fig. 1 Chest radiograph showing foreign body present in left lung

Fig. 2 CT scan showing a radiopaque foreign body obstructing the left lower lobe bronchus causing distal collapse and consolidation of the lung with an associated empyema

patient must still be referred on an urgent basis to hospital as it cannot be assumed that the object has been swallowed and not inhaled.

Bronchoscopy is the treatment of choice for removing inhaled foreign bodies.² Cases where the foreign body persists for more than 24 hours have been associated with increased morbidity and a longer hospital stay. Intense mucosal inflammation and granulation tissue may then impede the removal of the foreign body.²

We would like to remind the dental practitioner of a few simple preventive measures which can help to decrease the risk of aspiration: identification of at-risk patients,² the use of rubber dam for endodontic and restorative treatment,³ the use of a gauze partition at the back of the oral cavity,³ and the invaluable assistance of an attentive and effective dental nurse.¹

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