COMMENT

Letters to the editor

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Medical emergencies

Quick-release mechanism

Sir, syncope is the commonest medical emergency encountered in the dental clinic.[1] When an episode of vasovagal syncope occurs in the dental clinic early placement of the patient into a supine-with-legs-slightly-raised position is essential to correct the reduced cerebral blood flow. Delays in repositioning the patient can result in presyncope progressing to syncope, prolonging recovery.

In the rare event of a cardiac arrest, resuscitation with basic life support requires the patient repositioned into a supine position. In cases of hypoglycaemia and epilepsy also, recovery is aided by a supine position. In an emergency, precious seconds may be wasted in attempting to identify a preset button to place the patient supine. Studies have already questioned the efficacy of chest compression on the dental chair.[2] Chances of survival in cardiac arrest are further reduced if the clinician is slow to place the patient into a resuscitation position. A very low (0.3%) rate of cardiac arrest encountered in dental practice means that for most clinicians, a cardiac event encountered on the chair will likely be their first.[1] Hence there is a need for a dedicated, non-electric, quick-release mechanism in the form of a button or handle. This separate system would ensure quick visual identification and access in an emergency situation. Surveys of dental offices consistently reveal less than desirable preparedness of personnel to recognise and manage medical emergencies on the dental chair.[3]

In view of these observations, it appears that the provision of an 'emergency button' would be a prudent addition to dental chair design, which must go beyond aesthetics and ergonomics. Aside from rapid repositioning, the proposed dedicated emergency mechanical override also speeds up the process of making the patient supine; those precious seconds saved would be used to remove instruments from the oral cavity of a dental patient losing consciousness. A manual override safety mechanism should be incorporated into dental chair design.

N. Uppal, by email

1. Jevon P. Updated guidance on medical emergencies and resuscitation in the dental practice. *Br Dent J* 2012; **212:** 41–43.
2. Laurent F, Segal N, Augustin P. Chest compression: not as effective on dental chair as on the floor. *Resuscitation* 2010; **81:** 1729.
3. Girdler N M, Smith D G. Prevalence of emergency events in British dental practice and emergency management skills of British dentists. *Resuscitation* 1999; **41:** 159–167.

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Restorative dentistry

Heads in the sand

Sir, you have recently published two papers which aim to reduce the risk of wrong tooth extraction. This is rightly classified as a never event.

However, I would suggest far more restorable teeth are needlessly extracted than good teeth are extracted in error.

This is primarily caused by system failure in that an extraction and a root canal treatment attract the same NHS fee so a practice will make a profit on an extraction and a loss on a root canal treatment. Whilst very few dentists will deliberately extract a tooth they know is restorable, the economics will cloud the judgement of all but the most saintly of dentists.

There is also plenty of anecdotal evidence of restorable teeth being removed in order to place implants. This could be due to relative lack of knowledge as well as economic reasons.

In the case of the wrong site extraction a dentist has a duty of candour and must report himself to the authorities, subjecting himself to further investigation. In the case of extracting restorable teeth we can seemingly happily bury our collective heads in the sand.

S. Aaron, London

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Dental education

Difficulties in comparing standards

Sir, we have read with much interest the article by Oxley.[1] We recognise and appreciate the effort made to research the current state of dental education, as it is an area we believe needs to be studied with more depth, given its complexity, diversity and dynamic evolution.[2]

We noticed that the article does not determine a specific time frame to which the trainers can compare the standards of dental graduates. For this purpose, multiple time periods could have been added, for example 5, 10, 15, 20 and/or 25 years ago. For future studies, we believe this change would help to better evaluate the time trend.

On the other hand, we believe that – for future studies – it would have been relevant to include an analysis of why the standards in the formation of dental graduates may have declined. It is possible, for example, that dental education is currently required to cover a broader skillset than in previous years. One example of this is the area of promotion of health and disease prevention. A very high percentage of trainers indicated that graduates showed satisfactory preparation in this area.

Coincidentally, prevention in dentistry has only recently become a central part of dental training. This is part of a paradigm shift that is taking place in dental education: the change of focus from prosthetic and restorative dentistry to prevention and health promotion.[3] Nevertheless, we agree with the notion that the more clinical and technical parts of dental training should not be neglected.

In conclusion, it should be taken into consideration that with the incorporation of newer

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