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.

## OMFS

### Out of hours provision

Sir, I left NHS physiotherapy feeling that the tightening of the NHS purse strings was reducing quality. Physiotherapists who left were not replaced and senior physiotherapists were compelled to attend competitive interviews for their own jobs. Those who were unsuccessful were downgraded, many of whom subsequently left. The loss of these highly skilled and experienced staff resulted in a flattened Christmas tree model, with a reduced number of seniors providing expert patient care and training and support for juniors.

Now eight years on, I find myself with similar concerns as a dental core trainee (DCT) working within a busy maxillofacial unit. Historically, there would be a DCT providing specialist input with back up from a specialist registrar and consultant 24 hours a day. Now many hospitals have transitioned to an SOS doctor at night system where a number of surgical specialisms are covered by one surgical foundation year two doctor, often with limited maxillofacial training.

The aim of this is to cut costs, improve patient safety and to reduce out of hours service work to allow better, focused training during the day. However, one must guard against unnecessary admissions, reduced quality and access to care. The change creates the potential for patients being admitted unnecessarily and experiencing delays in treatment. For example, a laceration, which could be dealt with overnight and discharged, might be admitted awaiting specialist input or a patient with facial fractures not requiring immediate specialist assessment or surgical intervention might similarly be admitted overnight and may even be transferred from other hospitals unnecessarily.

This issue is likely to be intensified with the new junior doctor contracts where working hours are monitored and enforced with such vigour that training opportunities may be missed. For example, if the on-call DCT receives a referral for a patient in need of urgent dental treatment just before handing over to the medical SOS doctor, the current system does not allow the DCT to stay to provide this treatment. There is therefore a dichotomy in professional obligations. The responsibility one feels for the patient is trumped by the responsibility to honour the (ironically) educationally driven contract.

Not only could the recent changes result in reduced quality of care for patients, I believe they promote a lack of personal responsibility and dedication in trainees since these characteristics are not rewarded by the system. It is my opinion that returning to 24 hour DCT cover would benefit the trainees in terms of their experience and most importantly the patients in that they would be able to access specialist input in a timely manner. Although well-meaning, the SOS system and the junior doctor contract, as applied to DCTs, restricts learning opportunities and reduces access to specialist services. Emergencies occur out of hours; patients require treatment out of hours; and trainees can gain much experience out of hours.

*N. Kanoun, by email*

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## Medical emergencies

### Maths and methodology mix-up

Sir, the article *A ten year experience of medical emergencies at Birmingham Dental Hospital* (*BDJ* 2018; **224:** 89–91) made interesting reading but it appears the authors have got their maths and methodology completely wrong.

In the 'results' paragraph the authors explain 24 out of 119 cases were excluded from the analysis, because of missing information, leaving 95 cases. This seems to be supported by Figure 1 (bar chart with in total 95 people). Why then, in the results and summary, do they include these 24 cases again and use 119 as the denominator? You cannot exclude cases from analysis and then include them again in the denominator in your results and summary. But why are six cases with 'not enough information' included still, according to Table 1? Why were those not excluded as well? The total frequency of medical emergencies in Table 1 adds up to 115. Therefore, it appears another four were excluded (119 – 4 = 115). The authors state that in four instances there were multiple medical emergencies. So, 91 cases had one emergency only, leaving four cases with on average six simultaneous medical emergencies each (91 + 24 = 115)? That would have been very bad luck for these four individuals!

Even allowing for the basic error (re-including excluded cases) the figures in the results and summary are wrong. The authors are giving the impression 119 is the denominator. Cross referencing with the data in Table 1, it is hard to follow how the authors come to the percentages stated in the summary unless, at times, they use 115 as the denominator but not all the time.

For example, asthmatic attack occurred three times. The authors state this is 2.6%. As a percentage of 95 that is 3.2%, as a percentage of 119 this would be 2.5%, as a percentage of 115 this would be 2.6%. Vasovagal syncope occurred (according to Table 1) 42 times. If divided by 119 this would be 35%, not 36.5%. It appears 115 was used as the denominator here (42 being 36.5% of 115). They continue: 'cardiac arrest, stroke and iatrogenic events 1.7%'. Do they mean 1.7% *each*? Myocardial infarction occurred once (1/119) × 100% = 0.84%. Unless the authors used 115 again as denominator, then it would make sense (0.86% rounded up to 0.9%). But then why use 119 as the



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denominator in 'paramedic attendance' (48/119) × 100% = 40.3% as stated?

The authors conclude that BDH has a robust emergency protocol and recordkeeping system. How can a recordkeeping system with an incomplete record rate of 20% (24/119) ever be called robust?

*P. Nederlof, Evesham*

*The authors, S. Sooch, A. Kaur and B. Ahmed respond: We thank your reader for their comments. We need to acknowledge that the Datix system is a web-based online incidence reporting software usually completed by the dentist but in some cases by another member of the dental team. As investigators we access these data from the spreadsheet held by the governance manager. To our knowledge, this is the only way we can capture medical emergencies as reported by the dental team for our hospital. The Datix online reporting involves free text data input by the person filling in the report. This explains some of the discrepancies as some of the data are not documented and therefore we need to account for this. In saying this, we were stating that the nature of the medical emergency was known in 119 cases, however any additional demographic information (ie age) had been missing from some of the data entries; therefore the bar graph depicted a total of 95. Hence why Figure 1, which showed age groups of people affected and Table 1, which shows the frequency of medical emergencies, add up to different figures, as we were trying to depict these separately.*

*We excluded the four cases from 119 to give us a denominator of 115 (not from 95 to 91), as the dataset again was incomplete and we decided to continue with the 115 definitive cases and outcomes available.*

*We used the denominator 119 for paramedics called to the hospital, as the data were always available for each case regarding paramedic attendance as demonstrated in Figure 2.*

*Patient safety is a core value of our hospital; we like many other hospitals use the Datix system as a platform in recording untoward events such as medical emergencies. We accept the Datix system could be improved as it relies heavily on the information input by the reporters: missing data, a wrong clinical diagnosis input in the system can give rise to discrepancies; however, changing the system was beyond the scope of our project.*

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## Editorial decisions

### Outraged

Sir, I have been an avid reader of the *BDJ* since I was a first year dental student and I have never felt so compelled to write to you and express my outrage after reading the first two letters from Volume 224 No. 4, 23 February 2018, under the subheading 'Editorial decisions'.[1,2]

I would like you to know that I loved the cartoon cover arts, especially the one with the mouse and the fox. I always enjoy the different types of artwork on the *BDJ* and reading about their background.

As for the Christmas edition I simply cannot fathom why anyone would be against something light hearted and humorous. Dentistry is a tough profession and I am sure most dentists have felt down, depressed and anxious at some point. I personally feel the festive season can be quite overwhelming as there is a pressure on people in general to be all happy and jolly, but for us the same pressures still apply; indeed it can be an even busier time of year with extra patients. Reading something funny written by your fellow professionals could make the world of difference for someone feeling a bit low. It could bring a smile and some cheer for a dentist feeling overwhelmed.

I write this letter to assure you that the majority of the profession appreciate and enjoy the more light-hearted elements of the journal and request that this tradition continues. Yes dentistry is a serious profession, and yes we all enjoy reading the factual content of the journal, but having something fun certainly doesn't take any credit away from this well respected journal. Indeed it is of my opinion it actually makes it even more loved as the journal which is known to have something for every dentist no matter what discipline they are in.

*N. Jamil, Bury, Lancashire*

1. Sperber G. Editorial decisions: Diminishing credibility. *Br Dent J* 2018; **224:** 197.
2. Lawrence A J. Pathetic jokes. *Br Dent J* 2018; **224:** 197-198.

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### Grave concern

Sir, I am writing to you to express my grave concern regarding a recent entry for Zollipops in the *British Dental Journal*[1] under the 'Dental products and services' section.

Whilst I fully appreciate that the *BDJ* has a disclaimer at the top of the page indicating that the service does not imply endorsement by the *BDJ*, many dentists do not read this and would assume that because this has been published in a professional journal this product has some value.

The advert is basically for a sugar free lollipop – my concerns relate particularly to the logos being used to promote the product ie 'The clean teeth pops' and 'The after you eat treat for a healthy smile'.

Implying that eating a lollipop, regardless of when you eat it can somehow 'clean' your teeth is a very misleading message for the general public.

As health professionals it is imperative that we all give consistent, evidence-based messages to the general public. The statement that 'Stein Foods ... wants dentists to stand behind and promote the brand as a healthy and good way for parents to look after their children's teeth' really concerned me. Although sugar-free sweets may not directly damage teeth (some brands however can be acidic and could potentially be implicated in tooth erosion) regular consumption could help encourage a 'sweet tooth' which could certainly have implications for general health.

I do feel that the *British Dental Journal* is better than this and should be more proactive in filtering out unsuitable adverts before publication.

*J. Thomas, Swansea*

1. Product News. A lollipop that's good for your teeth? *Br Dent J* 2018; **224:** 118.

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## Dental careers

### To specialise or not?

Sir, I am writing to you as a recently qualified and aspiring dentist. Although I am in my early years, I find myself, like many of my other dental colleagues, at a career crossroads. With so many specialities and sub-specialities on offer as a dentist, it can often be confusing what to choose. I hear from many dentists that you don't need to specialise to excel within a sub-speciality. However, I hear from just as many that to excel and reach the pinnacle as a dentist, you should aim to specialise.

Does a dentist on the specialist register hold greater value and worth than one that isn't? Alternatively, will having an MSc, which has been obtained over a two-year period part time, put you in just as much demand as a dentist who has spent the last three years, working full time, on the specialist register?

With so many different courses on offer, it can often prove difficult to decide which one