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.

Dental regulation

Additional qualifications confusion

Sir, the current GDC's stance on the registration of additional qualifications (AQs) on the Dentists Register is completely unsatisfactory.

The position originates from the moratorium imposed in October 2007 on adding any further AQs to the register although those already present were left in place. The net result is a very odd situation: some dentists' AQs are listed, and yet the same qualifications from the same institutions, held by other dentists, are not. Therefore, the Register is now a strange combination of being current in terms of whose names appear on it, with the AQs frozen in time as of October 2007.

The GDC ran a consultation on this issue in 2008, so will be aware of the concerns expressed of achieving fairness towards registrants. For example, dentist X and dentist Y may have the same qualifications but one has only their BDS as an entry on the Register while the other has an additional string. This is confusing from a patient's perspective because there is a difference from the qualifications listed on the respective practice websites to those in the Register. They may reasonably regard the GDC Register as the more authoritative source and so wonder if one dentist is attempting to mislead them or if the other's qualifications are somehow 'inferior'.

This situation seems directly at odds with objectives that the GDC and its Chairman have stated. Early in his tenure, the GDC Chair said, 'So, it was, and remains, a central objective of policy that the customers for different healthcare services should be able to make rational choices, based on reliable information about the quality of performance of different providers...' The *status quo* is not 'reliable' for patients because of the

omissions. More recent GDC publications have stated the GDC's desire to make '... the system better for patients and fairer for dental professionals.'¹ The same publication picks up on the theme of public confidence, and the role of the regulator in promoting that.

Furthermore, the current situation appears to indirectly discriminate on the basis of age, since it will obviously disproportionately affect younger cohorts. The Equality Act 2010 imposes a legal requirement on public bodies to not apply a practice which creates indirect discrimination on the basis of age. A 2010 Council meeting paper hinted at recognition of this, 'The current holding position is unequal...'² The situation needs GDC review to ensure: fairness to registrants, that their actual policies and actions are in line with stated objectives, adherence to the spirit of the Equality Act, and promote public confidence by avoiding predictable misunderstandings.

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References

1. General Dental Council. Shifting the balance. GDC, Jan 2017. Available at https://www.gdc-uk.org/docs/default-source/shifting-the-balance/shifting-the-balance.pdf?sfvrsn=6653e3b7_2 (accessed November 2019).
2. General Dental Council. Additional Qualifications – their presence within the register. Item 5 Enc. D, Council Paper, 18th. 2 May 2010. <https://doi.org/10.1038/s41415-019-0995-y>

OMFS

Night shifts

Sir, we read with considerable interest N. Kanoun's letter entitled *OMFS: Out of hours provision*.¹ We recently completed dental core training (DCT) posts in oral and maxillofacial surgery (OMFS), which included first on-call duties overnight. We feel this element of the role provided numerous, unique opportunities for learning and served to deliver effective and appropriate patient care.

Entering such a role obviously requires one to successfully navigate a steep learning curve. We quickly gained confidence in efficiently assessing and managing a variety of acute presentations. Night shifts afforded the opportunity to use initiative and liaise with colleagues from other specialties to instigate optimal acute management. We were able to take greater ownership of patient care and gained confidence in prioritising patients on the basis of clinical need. Senior support was readily available and learning when and how to ask for it was a valuable part of the role. Following night shifts, feedback was provided on the cases seen and through debrief and guided reflection the learning from these patient encounters was maximised. These discussions provided excellent opportunities to link learning to the DCT curriculum.

DCTs are well-placed to effectively manage traumatic dental injuries (TDIs) when they present acutely to the emergency department. Injuries such as avulsions and luxations require expedient management; having a dedicated OMFS team of DCTs, registrars and consultants permits a 24/7 service, allowing such injuries to be managed in a timely and effective manner.² TDIs demand a thorough understanding of dental hard and soft tissues and an ability to effectively manipulate dental materials. Without these skills patient outcomes are compromised and the result may be long-term disfigurement requiring prosthetic correction. All dental graduates have a sound understanding of TDIs but this is unlikely to be the case for their medical counterparts.

ENT doctors provide overnight cover for OMFS in many units; consequently, patients may not receive immediate OMFS input. It has been suggested that this is to control costs.¹ However, untimely management of TDIs may be costlier in the long-run. In an effort to deliver a more cost-efficient system, is greater