COMMENT

Letters to the editor

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Clinical standards

Be prudent with resources

Sir, I write in response to the recent opinion paper by Barclay.[1]

The author clearly makes his point that sound craft skills are essential to successful training, and safety of the public. He also clearly describes the lack of correlation between communication and practical skills assessment, and that loss of a substantial component leads to a recruitment process that will fail to triangulate the candidate's suitability for training accurately.

Educational theory[2,3] would suggest that assessments should take multiple forms to achieve this triangulation, and thus it might be argued that a decision to remove a component that is not assessed elsewhere fails to conform to sound educational practice. Assessments may be summative, or formative. The latter are about identifying the progress of the learner – or assessment for learning. However, assessment for learning is also about assessing the suitability of the learner to progress to the next stages of the training programme.[3,4] To quote Lockyer *et al.*:[4] 'Educational systems need to maximise the probability that a physician graduating from residency training can provide safe, effective, patient-centred care.' However, many will also recognise that the acquisition of skills is a process that takes time, and students show great variability in progress. Weak students may struggle throughout part or all of training – but can turn things around. But at what cost?

Most will be familiar with the infinite monkey theorem – give a monkey a typewriter, and with infinite time the monkey will produce the complete works of Shakespeare. Now I am not – let me be clear – likening trainees to monkeys, but this points to an issue that appears to be ignored in all these discussions yet is more relevant to everything that the profession does from now on: resources. We live and work and train within a cash-constrained health system. We have just been through a series of damaging strikes, and if anyone thinks that more new money will be available for extended training – or even extra training places – I would suggest that it is time to read the writing on the wall. We do not have the resources to spend on candidates who are not a 'sure bet'. It is incumbent on the profession and the training organisations to be prudent with resources – resources that must be targeted to maximise the output from training programmes. One way to ensure this is that the candidates entering training are the very best in all domains – including clinical skills. To fail to recognise this is imprudent and fails to appreciate the scarcity of public funds.

I think I would have to agree with Barclay – that any recruitment process that does not manage this is not fit for purpose.

T. Thayer, Liverpool, UK

References

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3. Harris P, Bhanji F, Topps M *et al.* Evolving concepts of assessment in a competency-based world. *Med Teach* 2017; **39:** 603–608.
4. Lockyer J, Carraccio C, Chan M K *et al.* Core principles of assessment in competency-based medical education. *Med Teach* 2017; **39:** 609–616.

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Scope of practice

Direct access

Sir, I read with great interest the article in *BDJ Team* by Norfolk and Barnes regarding 'Direct access and scope of practice' (https://www.nature.com/articles/s41407-023-1981-4).[1]

The General Dental Council (GDC) introduced the Scope of Practice document in 2009. This document delineates the skills and capabilities that each dental professional is anticipated to have upon registration and can further develop throughout their career. Direct access was implemented in 2013, enabling patients to receive care from dental care professionals (DCPs) including dental hygienists and dental therapists (DH/DT) without the prerequisite of being examined by a dentist beforehand. Subsequently, numerous DH and DT have effectively delivered patient care through direct access.

The guidance made it clear that a DH/DT should not feel pressured to provide care under direct access. Therefore, prior to taking this decision, it is recommended a risk assessment be made taking into account the clinician's skills and training. Dental professionals should only perform a task or make a treatment decision if they are trained, competent and indemnified to do so. In the event that a referral to secondary care is required by DH/DT providing direct access, this should be made in the usual way providing the referral is justified. Moreover, if the recommended treatment plan exceeds their scope of practice then dental practices have a responsibility to establish a well-defined referral pathway to a dentist for appropriate management.

Open communication with the patient is vital to ensure they are fully informed prior to scheduling and attending their direct access appointment. Patients should be made aware of the clinician's scope and the possible limitations of direct access to reduce any confusion and ambiguity.

According to a review conducted by the GDC on the Scope of Practice document, dental professionals have indicated a notable lack of awareness regarding the scope of practice of others within the dental team. As a result, the GDC initiated consultations with key stakeholders to further examine and update the guidance. The process is ongoing, and a proposed draft of the guidance is available to access to all.