Letters to the Editor

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Priority will be given to letters less than 500 words long.
Authors must sign the letter, which may be edited for reasons of space.

LETTERS

DIFFICULT TO ACCEPT

Sir, I read with interest the paper from Brocklehurst and Tickle on skill mix profitability in the current NHS dental contract in England (*BDJ* 2011; 210: 303-308).

Whilst agreeing with the conclusions regarding therapists' financial viability within the NHS, I find their statements made regarding hygienists both surprising and difficult to accept.

They describe a process where 'treatment plans can be upsold' (p 306). It is not only the phrase, but also its implication which concerns me.

The authors appear to describe the upselling process involving treating the patient over an increased number of visits, hence revenue is increased. Whilst this may necessarily be true in private practice where patient payments are determined by an hourly rate, this is not the case for treatments under NHS funded contract. The treatment claim within the NHS is determined by the extent of disease and, *inter alia*, the diagnosis made by the referring clinician.

The patient referral pathway from dentist to hygienist is well described. A patient is referred to the hygienist for treatment within the Band 1 scale of patient charges subsequent to an assessment by a dental practitioner and prescription that this treatment is required. Whilst scope of practise does currently allow a hygienist to determine recall frequency, it does not allow a hygienist to re-diagnose disease.

Therefore, if a hygienist believes that further treatment is required which falls into Band 2 treatment then this 're-diagnosis' must be confirmed by a dental practitioner. This re-diagnosis will adversely affect the financial viability

calculation. The authors describe the hygienist working alone; whilst this may occur in some clinical practise, I would suggest to any hygienist considering a career of seeing patients without assistance and chaperonage that they seek advice from their indemnity organisation before embarking upon the practise.

Notwithstanding the diagnostic pathway required in such cases, the hygienist who encounters the need to 'upsell' on a regular basis may face an ethical dilemma.

Persistent re-diagnosis is evidence of persistent misdiagnosis. Persistent misdiagnosis must raise questions of fitness to practise and the professional obligations regarding reporting this underperformance, held by the hygienist, as a registrant with the GDC.

The financial implications of therapists practising within the current NHS contract have been well described within the Brocklehurst and Tickle paper. Having described concerns regarding their description of 'upselling' and demonstrated the need for re-diagnosis and increased clinical time involved, it might be argued that the financial justification of hygienists within NHS funded practise is similarly compromised.

However, there is pervasive opinion that hygienist-delivered treatment provides a financial advantage within NHS dental practice. Maybe this stems from the fact that most hygienists work under independently funded contracts irrespective of whether the patient arrived to them via an NHS or privately funded assessment and diagnosis. The ethical and consent issues involved are not for discussion here for I fear this opens another huge 'can of worms'.

However, evidence-based hygienists do exist in NHS practise, delivering independently-funded treatment, I believe, because our patients have become accustomed to having to pay extra for the hygienist. Patients have been programed not to question this and PCTs fear to become involved. Perhaps therefore, here is a way forward for therapists offering their treatment as an independently-funded alternative.

I fear this may not be successful since the often heard explanation that the hygienist can provide a 'more thorough clean' or 'specialises in gums' or 'is better at it than me' when a dentist attempts to explain the referral to an independently-funded hygienist, will probably not sound so compelling when describing 'a more thorough filling'.

Experience tells us not to rule it out since, as with hygienist-delivered periodontal services to NHS patients, a mantra, frequently repeated, however flawed ethically, can gain a momentum and fall into unquestioned acceptance!

Possibly the more ethically sound approach is to identify the important role played by dental care professionals in dental care and ensure that this is reflected in any new dental contract to ensure an improved, but this time ethically sound, service to our patients.

C. Roome
By email

Dr Paul Brocklehurst and Professor Martin Tickle respond: We welcome the views of Mr Roome, which clearly outline the ethical imperatives when referring to a hygienist. The context of our paper was to explore the use of different types of dental care professional from a business

perspective and why the current NHS contract makes it difficult to employ substitutive approaches, in contrast to supplemental ones.^{1,2} The innovative use of skill mix has the potential to increase technical efficiency, lower costs and reduce inequalities in service delivery, but is underutilised in dentistry.^{3,4} Academic research into technical efficiency is becoming increasingly utilised in healthcare,⁵ yet given that GDPs operate as small discrete enterprises, they are also acutely sensitive to incentives within the NHS dental contract.⁶ This paper provided a very brief and basic introduction into the economics of skill-mix. We intend to follow up this work with a Cochrane Effective Practice and Organisation of Care (EPOC) formal review entitled The impact of different methods of remuneration on the behaviour of general dental practitioners in primary dental care. This will provide an overview of the current evidence base for financial incentives on practitioners' behaviour and identify any gaps in our knowledge which need to be filled by future research.

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BUS DRIVER THREAT

Sir, I was interested to read the opinion piece (*Improving oral health among schoolchildren – which approach is best?* *BDJ* 2011; **210**: 59–61) referring to oral health improvement teams using modern inventions to suit the needs of the local population, using a multilevel approach and not using outdated methods.

I recall, as a community dentist in the 1980s, using a multilevel approach to try to improve the oral health of a group of adults in NE Hampshire who had moder-

ate to severe learning disabilities. There were about 50 people in the group daily attending a new Centre where the person in charge and the staff were enthusiastic and caring. The majority of the people attending the Centre had poor/bad oral health and most had not accepted an offer of dental care provision.

It was felt that oral health promotion to parents, carers and all staff would produce an improvement in oral health of the group. Sessions to talk about how to improve oral health were set up with staff, parents and carers all invited (including catering staff, cleaner and groundsman at the Centre) and substantial numbers attended these discussions and appeared keen to act. Over the following six months an increasing number of those with learning disabilities accepted dental care and it was obvious that the general attitude of those at the Centre to oral health and treatment had undergone a significant transformation.

When returning the following year to encourage the few remaining people attending the Centre who had not had any dental care to do so, it was disappointing to find several were still not willing to accept dental care. I suspected that maybe some parents, or staff had not maintained their apparent enthusiasm for good oral health from the previous year, but further investigation failed to locate any lessening of the previous cooperation.

But, a little later, I did find the person who was giving a negative message, which had resulted in people not obtaining dental care. He was telling them that in his experience going to a dentist was to be avoided. He was the bus driver driving people to and from the Centre every day who had not been invited to the oral health discussions the previous year and had not been thought of as a member of this relatively closed group of people at the Centre.

R. Rippon, Malaga

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ANTIBACTERIAL TWIG

Sir, in response to the request from R. Carr (*BDJ* 2011; **210**: 149) about a brown fibrous herb used by the Somali people to clean their teeth, I may be able to help. I have just returned from Lewa

Downs in Northern Kenya (only 200 miles from Somalia) where I ran a basic extraction clinic (with an Aid Kit from Dentaaid and sponsorship from Dental Directory) and where the local Maasai and Samburu tribes use brown twigs from the 'Toothbrush Tree' – *Salvadora persica*. The Swahili name is *musuake* and in Somali it is *ade* or *adhei*.

I took the liberty of having a twig analysed at Kew Gardens. It contains many substances, not least tri-methyl amine, high amounts of fluoride and silica, vitamin C, flavonoids and sterols. It is reported that it also has antibacterial properties, astringents and detergents. After several minutes of nibbling and chewing a twig, it frays into a fibrous mat not unlike a brush and leaves your teeth feeling really clean and smooth. I believe the company Sarakan Ltd in Beckenham put the powdered root in their products. There is no indication that it contains any toxic compounds but it may be worth checking.

I have also noticed a heavy dark brown stain on some patients' teeth but this is due to chewing the naturally available but mildly narcotic 'mirra' leaf which is horribly bitter. They therefore chew it with honey and sugar resulting in rampant decay – but that's another story.

R. O. Coleman, Cirencester

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SHEATH COMPLIANCE

Sir, further to the correspondence by R. Emanuel (*Br Dent J* 2011; **210**: 344) concerning resheathing of needles, examination of the quoted EU directive¹ states in Clause 6, Paragraph 1, 'Where the results of a *risk assessment* reveal a risk of injuries with a sharp...', only then is 'recapping' banned.

Risk assessment demonstrates when resheathing a dental local anaesthetic needle the operator's fingers are at least 3 cm away from the needle point; any healthcare professional who is unable to replace the sheath of such a needle without injuring his or herself is too clumsy to be allowed in a dental surgery.

To comply with HTM 01-05 the cleaning of instruments should be carried out in a room separate from the dental surgery. It is far more dangerous to handle and carry out transport of unsheathed