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.

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DCP LDS

Sir, what should the future direction of dentistry be? Should we be more active in preventive activities? These are just two of the questions posed by M. V. B. Nelson (*BDJ* 2012; **212:** 205–206).

It is undeniable that the profession should be looking at ways in which preventive dentistry can be enhanced. Dental hygienists are key players in this role. In most countries where they are trained, the hygienist course is at least three years. In the UK, the two-year training courses for hygienists have been severely curtailed. Whereas previously every dental school or hospital in the UK had a hygienist training course, now there are only five. The remainder have been replaced by combined hygienist/therapist courses of only 27 months (of which there are eight), or by three-year degree courses (a further eight). Only one school provides the therapy course as an 'add-on' for dental hygienists (data gathered from a recent analysis of websites of training establishments providing hygiene and therapy education, as listed by the GDC). DCPs are trained to perform a high proportion of the day-to-day procedures undertaken by dentists in general dental practice and it is a credit to the teachers and students that there have been, to my knowledge, no major criticisms of the abilities of those qualifying under the 27-month programmes. Nevertheless, are they the best way forward?

There is considerable demand for hygienists in general dental practice but there seems to be little demand for dental therapists. There is anecdotal evidence that many DCPs are having difficulty in gaining employment that uses their dental therapy skills and they have to work solely as hygienists. Unless the demand for therapists increases, they are at risk of becoming deskilled in this aspect of their work and their training will be wasted. Also, are we discouraging potential applicants who are dedicated to prevention rather than to restorative dentistry?

With increasing deregulation in the health services and in other professions, perhaps it is not surprising that there is pressure from some DCPs that they be permitted to undertake independent practice. Should this be resisted?

In this rapidly changing environment a fresh look at manpower issues is needed, especially hygienist/therapist education. The following proposals could be a starting point for debate: an expansions of hygienist-only training using two- or three-year programmes (comparable to Europe, the USA and Canada); dental therapy training to be one- or two-year add-on courses to dental hygiene training. Only sufficient places to be available to meet the demonstrated demand and need for dental therapists.

Although most of us support the idea of a team approach to dentistry, if independent practice by DCPs does become a reality, then a three- to four-year course for a fully trained hygienist/therapist may be deemed to be acceptable.

In the middle of the last century, the LDS course (one year shorter than the BDS course) was phased out of universities. Perhaps 'LDS' should be resurrected as a registrable first qualification for the DCP graduates of these longer courses.

The profession must plan for the future, not drift into it.

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AUTOMATON BEHAVIOUR

Sir, I write to offer my opinion on the case highlighted in the letter from J. Rowarth (*BDJ* 2012; **212:** 259) based on the limited facts in the letter.

The decision to prosecute (ie bring a summary proceedings against the patient) was for the Crown Prosecution Service (CPS) to make. However, not all crimes will automatically be prosecuted. The CPS retains discretion to prosecute which should be exercised in accordance with published guidelines. The CPS must have been satisfied that there was enough evidence to provide a 'realistic prospect of conviction against' the patient (The Evidential Test) *and* that the prosecution was 'in the public interest' (The Public Interest Test).

We are not told with what offence the patient was charged but there is an alleged forgery [see Forgery and Counterfeiting Act 1981, section 1 – an offence triable either at the Magistrate Court (summarily), as in this case, or at the Crown Court (trial by jury)].[1] The general rule, expressed in the maxim, *actus non facit reum nisi mens sit rea*, is that an offence can be committed only where the criminal conduct is accompanied contemporaneously by some criminal fault – a guilty mind. The patient had received their treatment under IV sedation. It could therefore be argued[1] that she altered the prescription whilst under the influence of the midazolam (intoxicant) in her system and not voluntarily; she also lacked the requisite guilty mind to defraud. In short the midazolam made her behave like an automaton!

Involuntary acts will not attract the sanction of the criminal law, hence a defendant who committed a prohibited act in a state of automatism will have a