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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LETTERS

Ed's note: The issue of whether or not the public should have direct access (DA) to DCPs, notably dental hygienists and therapists, has garnered a lot of correspondence, all in favour of DA. We publish here a representative sample.

RECOGNISING MALIGNANCY

Sir, I write in response to the letter by A. C. L. Holden (*No to direct access*; *BDJ* 2012; 212: 355-356). The initial training course for dentists is indeed longer than that of most dental hygienists and therapists although the graduate entry programmes at UCLan and Peninsula are equal in duration to the BSc (Hons) at Edinburgh. However, surely it is the content and learning that are relevant to the scope of practice rather than the duration.

The learning of all dental professionals is lifelong and new knowledge and skills are continually being gained. In respect to the ability to 'diagnose' oral cancers and mucosal conditions, dental hygienists and therapists can learn relevant skills just as dental students do. I am sure that many would acknowledge that they would benefit from such training and welcome the opportunity.

As a dentist I have recognised malignancy in my patients. I have referred them to a colleague who has treated them based on the report of a pathologist, rather than my suspicions. I recognise that I do not have the training or skills to make the final diagnosis. An identical pathway is available to dental hygienists and therapists.

M. Wanless

By email

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SMALL-MINDED COMMENTS

Sir, on reading the letter by A. C. L. Holden (*No to direct access*; *BDJ* 2012; 212: 355-356) I was slightly outraged by what I thought were the author's inaccurate, ignorant and small-minded comments and felt compelled to reply. I am a dental therapist (DT) and am currently the North East Representative for the British Association of Dental Therapists (BADT).

The author raised concerns that direct access (DA) would not be in the best interests of patients. However, if a patient presents with a lost restoration and the dentist is busy, with DA we could see the patient, assess best treatment and refer accordingly to the dentist. We do recognise that restorations fail for a number of reasons and what the correct treatment should be.

The author raised the fact that DTs have a shorter education and so it is beyond our competency to diagnose, but if we had DA we could have further training. Indeed it would be foolish and a little insulting to the GDC to assume that we would be allowed to have DA without having any further training to ensure competency. Currently we can prescribe (with additional training), interpret radiographs and are expected to be able to identify caries to be able to remove it, so why with additional training to consolidate and develop our diagnostic skills could we not be allowed to diagnose caries and manage it accordingly?

The author stated that dental surgeons are often the health professionals patients see most frequently. In practices that utilise a DT, it is in fact often she or he who sees the patient most frequently. The dentist does the initial diagnosis and then the DT carries out

the oral hygiene advice, scaling or periodontal and restorative treatment (within our scope of practice), which may take several visits alongside any treatment with the dentist. The patient may then go on to be supported by the DT with regular visits for a scale and polish and continued oral hygiene.

The author goes on to say that dentists are relied upon to diagnose oral conditions such as oral cancer and mucosal disorders and that giving DTs the responsibility to diagnose such conditions is 'bordering upon neglecting patients' rights to proper treatment'. At present we do have to rely upon a dentist to make a diagnosis but that is *only* because DTs cannot diagnose as part of their scope of practice. This doesn't mean we are incapable of diagnosis with further training and change to our scope of practice. DTs receive training in recognising changes in the oral environment and are able to use their clinical judgement and refer to the dentist where they deem it necessary.

In the letter, the issue of public perception is mentioned and the author states 'It is unacceptable to place the public in a situation where their capacity to provide informed consent is impaired due to not knowing by whom they are being treated and what their role is'. My response to this is dentists currently lead the dental team and as such should communicate effectively to their patients what roles members of the team in the practice play. We should all be working together to raise awareness of the different roles within the dental team and make our patients aware of how our scope of practice is expanding with additional skills. If you have a DT in your team you should be making your patients aware