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

of what their role is so that the patient can provide informed consent based on this information. If you are not currently doing this and this is the reason for the impaired ability to consent then you are not fulfilling GDC standards.

Since all the author's points can be contested this group of dentists' argument against DA is invalid. I can only assume that this group of people feel their own role is threatened by the idea of DA. In terms of setting up alone, a DT can already do this and so introducing DA is unlikely to see a significant increase in independent practice in competition with existing practices. Dental teams must work together in the interest of the patient and if DA was to go ahead there would be treatment that dental therapists could not carry out so referrals would be made accordingly and this would be best arranged within a single practice. Introducing DA would mean that patients would be able to see the DT for an oral health needs assessment, routine treatment and preventative practice, freeing up time for the dentist to carry out the more complex treatments. Also, a DT's time is cheaper than that of a dentist. How can this change not be seen as a positive move for both patients and the dental team alike? There would be nothing stopping practices working in the existing way so if you personally do not want to work in this way then fine, don't; but this may work well for some practices and it would be unfair on both the public and the profession to dismiss this idea.

M. Joyce

By email

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PERIODONTAL THERAPISTS

Sir, on the subject of direct access (DA), your readers may be very interested to read an article by Colleen Rutledge called *Heeding the call and committing to periodontal therapy* (www.perio-andbeyond.com), in which she states that in the USA some dental hygienists (DHs) are being trained as periodontal therapists (PTs), to work in conjunction with the dentist and periodontist. The PT receives training in advanced non-surgical periodontal therapy and is responsible for carrying out phase one

treatment within a general practice.

In June 2009 I attended the Eastman Dental Institute for a four day intensive training course on advanced non-surgical periodontal therapy (NSPT) for the hygienist. This was an immensely enlightening course, covering all aspects from risk factors through aetiology, radiographs, treatment planning and instrumentation. The course was spread over four weeks, with plenty of reading material and revision of notes in between. By the end of the course I had a far better knowledge and understanding of periodontal disease, and most importantly, how to treat my patients in practice. A few months later I undertook the necessary training, again at the Eastman, to administer inferior dental nerve block local anaesthesia.

I consider that, through this training, a new category of hygienist – the PT – may evolve as a conduit between dentist and periodontist which many practices would benefit from. It goes without saying that a PT would benefit from DA to patients, though this would inevitably involve diagnosis, which is another bone of contention within the profession. This clinician would be in a position to accept referrals from GDPs, but this service could be offered to a wider range of the general public if treatment was available to potential patients without the necessity of going through a dentist first. The PT could accept patients in their own right from self referrals, just as patients attend a physiotherapist or podiatrist. In turn the PT would be permitted to refer the patients on to a periodontist for more extensive treatment, should the need arise.

Indeed DA for DHs is long overdue and would raise their esteem. Owing to the importance of clinical experience DA should only be considered after a DH has been qualified for five years and I would suggest that advanced training to become a PT should also bear the same condition. More dental schools could offer the same type of course I attended at the Eastman, so that DHs throughout the country would be able to take advantage of this new qualification.

H. Parkin RDH

By email

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STALKING HORSE

Sir, I would like to comment on the letter by A. C. L. Holden (*No to direct access*; *BDJ* 2012; 212: 355-356). I am a dental hygienist with nearly 30 years' experience in dentistry. I am also an active campaigner for direct access. I've worked full time in general practice for most of that time, only taking time out to work part-time for various dental companies. This was mainly in the software and intra-oral imaging sector. I'm part of the management team in a busy, large, predominantly private, city centre practice. I am also a mentor for the Philips Transitional Support Scheme that supports newly qualified hygienists' move from education to life in practice. I take patient care and safety *very* seriously.

I believe that Holden may have exposed his lack of years as he appears to have been used as a sort of stalking horse. That is the opinion of a couple of my peers who have read the letter as the argument is very simplistic; on first reading it has merit but on deeper investigation holds no water.

D. Bridges RDH

By email

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DRACONIAN REFERRAL SYSTEM

Sir, I wish to reply to the recent letter the letter by A. C. L. Holden (*No to direct access*; *BDJ* 2012; 212: 355-356). I totally disagree with the points raised regarding dental hygienist-therapists and direct access to patients. I found the tone and content of the letter derogatory to dental hygienist-therapists.

I would like to clarify a couple of points. Holden claims that as dental hygienists-therapists have a shorter professional education than dentists it is therefore beyond our competency to diagnose dental conditions. Additionally, that dental surgeons are often the health professional patients see most frequently, so they are the health professional relied upon to diagnose oral conditions such as oral cancer and mucosal disorders. He then goes on to suggest that giving non-suitably trained professionals such as dental hygienist-therapists responsibility to diagnose such conditions is bordering upon neglecting patients' rights to proper treatment.