The role of the scapegoat

Dave Martin discusses giving hygienists and therapist direct access

I took the plunge in 2002 to work as a self-employed therapist in general dental practice. Nine years on and things seem to be getting a little worse for the employment of therapists. This is rather puzzling, not to mention worrying, as many training centres (especially in my region of the North West) were set up to deal with the short fall in dental access. My understanding is that dental therapists were to be trained to help alleviate dentists’ workloads. I can’t help thinking that something has gone wrong somewhere.

I speak from my own experience so appreciate that this might not be generalisable, but when I qualified it wasn’t so hard to secure a post.

To get full time therapy work has been difficult so my week involves a combination of therapy and hygiene. When I worked in bigger practices it was only the principal who referred to me for restorative work, because the associates were unprepared to lose money or a UDA value for referring. Restorations that are referred to me and other therapists are usually beyond repair or without recent radiographs and extractions are referred on non-cooperative patients. Sometimes I have felt like a scapegoat, and with a preponderance of difficult or non-cooperative patients referred onto me.

Experiences and anecdotes shared at conferences and local meetings only consolidate this fact alongside many different concerns about below par dentistry and treatment purely for financial gain. I appreciate that I appear to be rocking the boat but I may add that I have been fortunate to work with some excellent fellow professionals so I do not tarnish everyone with the same brush.

Our experience of under graduate training means that boundaries, remits and legalities are drummed into us so we qualify with a good perception of what is right and what is wrong. You only have to look at the number of hygienist or therapist cases in the back of the GDC gazette to get a feel.

So we look to lobbying the GDC to prove that we can see patients directly. Is this in the best interests of the patient? Dentistry is the only professional system that I’m aware of which patients are referred for dental treatment purely for financial gain. I appreciate that this might not be generalisable, but looking at the coal face of dentistry it seems we have to prove ourselves worthy of even straightforward referrals. Why?

We are competitively trained and able to provide a high standard of primary care dentistry. The entry level requirements for our academic courses may not match those for dentistry but this does not render us second rate in terms of our clinical competence. There is clear evidence of the value and benefit to a dental health system of appropriate and successful usage of dental therapists which is seen across the globe for many years, so why is it not seen in the UK?

Therapists in Canada, Malaysia, Tanzania, China and New Zealand all have direct access with great effect. It is interesting to note that in Malaysia after 50 years of direct access not one case has been brought against a dental nurse (therapist). Malaysian dental nurses are currently in the process of trying to get their name changed to dental hygienist/therapist. In New Zealand the benefits of utilisation of dental therapists within their school dental service is well documented. They have used dental therapist for more than 80 years. There they have a consultative role with dentists who are not required to treat patients.

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Under-graduate training for therapists has given them a good perception of right and wrong.
down! This is in contrast to medicine’s upward referral system in which a doctor will refer a patient to a specialist if s/he is unable to deal with a particular problem, or a practice nurse will refer up to a doctor if s/he cannot deal with a condition. It’s time dentistry is brought in line with medicine!

We are all trained in intra oral and extra oral assessments included in our remit and we have comprehensive training in spotting potential suspicious lesions. We all treat caries and periodontal disease yet I don’t see how we do this effectively without being able to identify, or dare I say, diagnose these diseases.

BSDHIT and BADT joined forces on the 23rd of February and invited the newly formed GDC to an evening of presentations from both associations. The setting was Chandos House, just a stone’s throw from the GDC headquarters in London. Sally Simpson (President BSDHIT) and Kia Stearns (Chair BADT) chaired the evening’s talks and past BSDHIT president Margaret Ross gave an inspirational presentation on education. Margaret made it clear that training of hygienist and therapists is equal to that undertaken by undergraduates. She approached the subject of direct access head on with great effect. This was followed by presentations from clinical hygienists Michaela O’Neil and clinical dental therapist Charlotte Wake who talked about their daily working life and how direct access would improve their patients care.

Dentist Graham Dindol then talked about skill mix within his practice and how he utilises both hygienist and therapists successfully with no detriment to quality of patient care. Dentist Tony Newton from the British Dental Health Foundation provided a short synopsis on how direct access would enhance the oral health needs of the public.

Finally Mike Wheeler, past president of the BSDHIT, rounded the event up perfectly highlighting the excellence of dental hygienists and therapist work and thanking the GDC for their support throughout the years in expanding the remit of DCP’s and recognising skill mix within the field of the clinical world of dentistry.

The evening was also a fantastic opportunity for both associations to meet the new lay members of the GDC. They come from all walks of life and are very experienced in regulation of different aspects of health care. They are surely a great asset to the new GDC and hopefully will provide balanced views for direct access for dental therapists and hygienists.

With consultation and robust educational objectives therapists and hygienists can hopefully take on patients directly freeing more time up for the dentist to see emergencies or provide advanced care thus improving access and availability. This after all is what we were trained to do. Dentists can be assured of a preventive focus for delivery of patient care and a greater integration and true skill mix within their practices. With new pilots schemes underway throughout the UK DCPs should be well placed to provide a great service in line with the Department of Health’s main objectives of provision of dental care to the nation.

About the author

Dave Martin a dental therapist, Manchester and Thameside, started as an apprentice dental technician. He started out working in a dental lab, working for a short while as a dental nurse, and then trained for two years full time to be a dental hygienist. He followed that with two years’ part-time training as a dental therapist. The NHS helped him to move up the career ladder with a grant and a small bursary for so he could train as a dental therapist. He says that one of the joys of the job is helping someone who is nervous get through their treatment and become more confident and that it’s good to work with children – teaching them good habits that will keep their teeth and gums healthy. Dave is currently self-employed and works in different practices, carrying out routine work under the direction of the dentist, allowing the dentist to focus on more advanced procedures.

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