Conversations at the water fountain

Dental Hygienists Sarah Murray and Christina Chatfield discuss Direct Access and the importance of having your say on this controversial issue

Sarah Murray (SM): So Christina, Dental Health Spa is five years old this year; what’s on the agenda?

Christina Chatfield (CC): Hopefully to see a change in the way that patients can access hygiene services would be great. I suppose in my naïvety five years ago I thought that Direct Access was around the corner because of the strong recommendation from the Office of Fair Trading (OFT) to remove the ‘under prescription’ rule. This recommendation came about because of a super complaint made by the Consumers Association (WHICH) in 2005. The OFT report did make a number of recommendations, one was to allow registered professionals with the GDC, other than dentists, to set up and manage the business of dentistry; hence independent practice was born. It is a tough and challenging working environment which any dentist will tell you and it is no different for me but it’s certainly not Direct Access.

Here we are, nearly a decade on and the OFT are relooking at the issue of Direct Access and the OFT are relooking on and the OFT are relooking at the issue of Direct Access. It is a tough and challenging working environment which any dentist will tell you and it is no different for me but it’s certainly not Direct Access.

Unfortunately the ‘under prescription rule’ still stands – a patient cannot see a dental hygienist or therapist to have their prevention and oral hygiene needs met without a dentist’s permission. However, they can take a copy of their treatment plan to any clinician of their choice. My experience, which is shared by many of my colleagues, is that very few patients are given an in-depth treatment plan, a diagnosis or even an accurate BPE.

Sarah Murray (SM): BPE has been around for nearly 25 years and is taught as part of the undergraduate training, irrespective whether the student is studying BDS or hygiene/therapy; they are taught together. All the students’ learn this in their second year, so it gives them ample time to consolidate this and use it as a diagnostic and treatment tool. When our competence is constantly questioned, it should be noted that as our scope of practice has changed over the years, so has the robust core training programme that underpins our profession.

CC: Sarah, with such a simple diagnostic treatment tool that’s been around for 25 years, why in the most recent Adult Dental Health Survey, are perio disease levels still so high?

SM: Well I think people have ‘white coat syndrome’ and get nervous about seeing their dentist. In a survey by the British Dental Health Foundation for last year’s launch of National Dental Hygiene Services, it was stated that people were more frightened of their dentist than they were of snakes and spiders. Patients are consumers at the end of the day, who want fresh, white teeth and healthy gums, and they feel that hygienists and therapists provide this and are (as a professional group) possibly seen as less threatening.

CC: I agree with you, the Adult Dental Health Survey also said that 12 per cent of the population do not go to the dentist due to dental anxiety, so, this core group do not receive any oral cancer screening, any prevention advice or smoking cessation advice. Why then, in the 78 per cent that do go to the dentist, is the level of peri-odontal disease so high? One might question if the BPE, the very simple diagnostic tool that we are all taught, may not be being used accurately or widely enough.

SM: It is true to say that students know how to carry out a BPE, what pressure to put on the probe (12g of pressure), they know about angulation and they are aware of operator variables, so it is being taught and used in dental school, but we don’t know the uptake of this after they leave. Is it being used? Is it accurate? Do we know how many hygienists/therapists are using the BPE in their treatment plans? How many of the teams actually calibrate their dentists to ensure intra and inter operator accuracy? In terms of a clear diagnosis, other than a dentist saying the patient has gum disease – how many times are you advised whether it is chronic or aggressive – you are often left to decide this for yourself. Evidence is the key thing here and whilst we all know that we often receive no treatment plans or accurate diagnosis we don’t have the evidence. This is why we are asking that dental hygienists and therapists help us collate the evidence that we need to support this. Our survey seeks to establish the evidence surrounding referral practice for dental hygiene treatment. Please complete our Survey Monkey questionnaire. Even if you are happy with the status quo, we want your views. Join the 300 who have already completed the survey. You are asked to give your GDC number for validation purposes only this data will be collated without reference to the participant.

Go to www.surveymonkey.com/IKK8C56P or go to www.bdhs.org.uk and click on Direct Access Action Group survey on their front page.

The GDC is also asking for your views please take time to fill out their survey, https://response.questsback.com/thegeneraldentalcouncil/yvijrnkni/

Change won’t happen if you say nothing at all.

About the authors

Sarah Murray teaches dental hygiene and therapy at Barts and The London School of Medicine and Dentistry, in addition to teaching at the University of Essex. She believes that both dental hygienists and therapists have the skills and abilities to undertake Direct Access for patients acting in the patients’ best interest.

Christina Chatfield, a dental hygienist, is clinical director and owner of Dental Health Spa Ltd in Brighton. She has more than 20 years’ experience in practice and qualified from Dundee in 1982. She is currently studying a two-year Diploma in Periodontal Therapy.

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