Scope of Practice Consultation

Response to GDC Consultation
April 2008
Introduction

Dental Protection Limited (DPL) is a wholly-owned subsidiary company of the Medical Protection Society (MPS) which is the world’s largest professional indemnity organisation for doctors, dentists and other healthcare workers, having over 250,000 members internationally. The two companies operate on a mutual, not for profit, discretionary basis as they have done successfully since 1892.

DPL serves over 51,000 dental members in 70 countries worldwide. This total includes approximately 70% of UK dentists and a higher proportion of UK dental therapists and hygienists. DPL also indemnifies the overwhelming majority of dental care professionals (DCPs) in Australia and New Zealand. Where many of the issues discussed here have been a reality for many years. DPL is therefore uniquely placed to provided comment on the consultation document.

DPL currently offers professional indemnity to dental nurses working in general and specialist dental practice under its existing subscription arrangements, provided their employer is a full member of DPL and is paying the appropriate subscription. In April 2007 DPL extended its membership to all DCPs with a wide and varied subscription options to suit the requirements of each individual DCP, including those who take the opportunity to own and operate dental practices or dental laboratories.

DPL welcomes the opportunity to comment on the General Dental Council’s (GDC’s) consultation on the scope of practice. The Council will be aware that DPL is a strong advocate of the concept of an integrated dental team and continues to support the expansion and registration of that team.

DPL recognises the importance of the GDC’s documents in establishing the principles and values expected of the profession as a whole. In addition DPL agrees that only appropriately trained, qualified and registered members of the dental team should be permitted to practise dentistry. DPL similarly recognises that each registrant has a responsibility to ensure that dentistry is practised within the limits of the registrant’s training, expertise and competence and that it would not be appropriate to undertake procedures for which the registrant is neither qualified nor trained.

DPL believes that team working in dentistry requires that the right mix of skills and people interact. The key issue is striking the right balance between team members who already posses the necessary skill levels and those who have the potential to train and develop.

The activities of each individual member of the team regularly impacts on the way that problems arise and more importantly from DPL’s point of view, on the way that they are resolved. As such DPL has a special interest in the outcome of this consultation. Not only would it wish to see the individual members of the team extend and expand their skills but it must also look to providing effective indemnity to its members. Not knowing the range and scope of practice duties normally undertaken by each individual dental team member makes meaningful and fair indemnity subscription setting extremely difficult.
General Comments

The guidance offered by the GDC in 2005 presented a wide definition of practice, bound only by the need for the dentist to undertake a full mouth assessment of the patient, the provision of an appropriate treatment plan and the training and competency of the team member who was to carry out the treatment.

DPL believes that redefining the existing parameters sympathetically to reflect those duties “normally” carried out by each of the registrant groups, might well be restrictive in nature but is of help in that it does provide a reference point for the profession in relation to the normal scope of practice. In addition it also offers reassurance to members of the public that the individual clinician undertaking treatment has received the appropriate training, acquired the necessary skills and therefore has the competence to carry out that treatment.

The reality is that dentistry however involves individual patients being treated by individual members of the dental team, in individual ways. Looked at from the indemnity point of view, no two clinicians have the same risk profile because they will have different skills and experience. They are by definition supported by different team members with different strengths, weaknesses and training, and they will perform a different “mix” of dental procedures on a different “mix” of patients.

Consequently, DPL believes that it is not possible to produce a specific universal list of additional duties and skills that set predefined boundaries for each individual dental team member, without recognising the competency of that individual, what training they have undertaken and in some situations where and when that training took place.

By way of example, specific diagnosis of a wide range of common dental conditions is taught on all undergraduate dental degree courses but is not normally taught as part of a DCP’s initial training and yet with clinical experience and further training it is likely that any DCP and in particular a hygienist, therapist or clinical dental technician may well be just as able to specifically recognise caries, periodontal disease and other common dental problems as are their dentist colleagues. He or she by the very nature of their competency may also have an appreciation of what treatment alternatives may be realistic and possible for that patient without necessarily feeling comfortable in producing a specific treatment plan for a condition that is outside of his or her area of expertise. Such a statement is just as true for a DCP as it is for a dentist. A clinician who has insight into his/her personal competence, and that of other colleagues, is well placed to know when a referral up (or down) the chain of expertise is indicated.

When a clinician is faced with a dental condition that is outwith their area of familiarity, they are taught to make the necessary referral to a more experienced colleague. Indeed the GDC’s guidance would reflect this. (Principles of Team Working – paragraph 3.4, 3.6 & 4.10). To suggest then that only dentists are able to make this judgement somewhat undermines the skills of an experienced and competent DCP and their professional integrity. This is a matter of judgement and competence, not of training per se.
DPL is of the opinion that producing a definite list of additional skills for a DCP that would indicate that a DCP does not undertake certain tasks (i.e. diagnose of dental disease) is perhaps at best misleading and at worse inaccurate. Such additional skills depend on the individual’s competency, experience and training.

DPL would also endorse the view that any extended list of additional skills where it to exist, should allow a degree of latitude for those registrants who would wish to undertake further (and in some cases extensive) training. This will undoubtedly provide a far more structured basis for the development of dental practice.

We believe that the “normally” undertaken duties and any additional skills list should be set on a competency basis to reflect the individual and the current nature of dental practice.

It would of course be for the registrant (dentist and DCP) to demonstrate to the satisfaction of the GDC’s fitness to practise committee if required, that whilst undertaking any additional skill that is not normally taught within the registrant’s initial training, that they had the necessary competency to carry out the task.

**DPL therefore supports a competency based approach whereby the Dental professional can demonstrate appropriate training to support an area of practice.**
Questions

Dealing then with each of the specific questions:

<table>
<thead>
<tr>
<th>1.</th>
<th>Do you think the definition of the practice of dentistry should be amended to cover advice and treatment given by all GDC registrants (rather than just dentists) to protect the public from unregistered staff by protecting the functions of dental nurses and technicians in law as well as their titles?</th>
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<tr>
<td>Yes. Substitution of the word “dentist” with the phrase “registered dental professional” would seem logical.</td>
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<th>2.</th>
<th>To help us understand the context of your response, please indicate the perspective from which you are replying.</th>
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<td>On behalf of an organisation – Dental Protection Limited (DPL)</td>
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Dental Nurses

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<th>3.</th>
<th>Is there anything that should be added to a dental nurse’s scope of practice?</th>
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<td>The list provided would appear to reflect the duties normally taught as part of a dental nurse’s initial training.</td>
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<th>4.</th>
<th>Please identify anything that you would add or remove from the proposed additional skills for dental nurses and give reasons.</th>
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<tr>
<td>Skills that should be added…</td>
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As indicated previously DPL supports a competency based approach whereby the Dental professional can demonstrate appropriate training to support an area of practice. Please refer to the general comments made earlier in this submission particularly in relation to additional skills.

In more specific terms:-
There is probably very little reason why some of the “additional skills” indicated could not easily be taught as part of a dental nurse’s initial training.

By contrast other skills need further definition and clarification. Taking impressions and face bow registrations (e.g. for study models) may well be within the competency of an average dental nurse with additional training, but the same clinical procedure for a complex advanced restorative case may well involve clinical skills that the average dental nurse is unlikely to possess without extensive additional training. The procedure itself is often less relevant to competency than the context in which it is carried out.

Similarly DPL feels that the polishing of teeth with rotary instruments (by which it is assumed the GDC are referring to a dental hand piece) is perhaps of little benefit to patients without the appropriate oral hygiene, scaling etc.

The difficulty in producing such a list is also demonstrated by the fact that there are also some notable additional practice skills missing from the list even thought they would generally be considered as being well within the competency of a suitably trained dental nurse. For example:-

a. Removal of sutures following a review of the patient by a dentist.
b. Dressing of teeth with a temporary dressing in an emergency.
c. Dressing of a dry socket with a suitable material in an emergency.

It is not clear why the GDC did not feel that these duties should be added.

Skills that should be removed…
None

Orthodontic Therapists

5. *Is there anything that should be added to an orthodontic therapist's scope of practice?*

   The list provided would appear to reflect the duties normally taught as part of an orthodontic therapist’s initial training.

6. *Please identify anything that you would add to or remove from the proposed additional skills for orthodontic therapists and give reasons.*

   **Skills that should be added…**

   As indicated previously DPL supports a competency based approach whereby the dental professional can demonstrate appropriate training to support an area of practice. Please refer to the general comments made earlier in this submission particularly in relation to additional skills.

   In more specific terms:-
DPL does not understand why the GDC felt that orthodontic therapists should not be able to undertake certain fundamental tasks as their exclusion would not seem to be in the best interest of the patient.

The use of local analgesia for example is not defined, but it is assumed that this relates to the use of local anaesthetic injections by infiltration. This seems an unnecessary exclusion. The removal of brackets and bands in orthodontic treatment can for some patients be uncomfortable and may necessitate the use of local anaesthetic. There would appear to be little reason why a suitably trained orthodontic therapist should not be entirely competent in its use.

In addition the placement of temporary dressings in an emergency would seem to be logical duty for any competent registrant. It is possible for example that when a band is removed from around a restored tooth that the restoration itself could becomes dislodged. If the dentist or another suitably trained DCP is not available to place a temporary dressing, the best interests of the patient are unlikely to be served by prohibiting the orthodontic therapist from providing first aid relief such as this.

Skills that should be removed…
None

Dental Hygienists

7. Is there anything that should be added to a dental hygienist’s scope of practice?
No

The list provided would appear to reflect the duties normally taught as part of a dental hygienist’s initial training.

8. Please identify anything that you would add to or remove from the proposed additional skills for dental hygienists and give reasons.
Skills that should be added…

As indicated previously DPL supports a competency based approach whereby the Dental professional can demonstrate appropriate training to support an area of practice. Please refer to the general comments made earlier in this submission particularly in relation to additional skills.

In more specific terms:-

It is suggested that hygienists may carry out “periodontal surgery” this term is not defined. Periodontal surgery can cover a wide range of surgical procedures, some of which are relatively simple whilst other (i.e., reverse bevel gingivectomies, free gingival grafts etc) require considerable surgical skill within the mouth that are perhaps a long way outside the current initial training provided to hygienists.

It may be realistic for an individual hygienist who possesses these skills to carry out such procedures but it would be necessary for that hygienist to be able to demonstrate their competence if challenged.
Further consideration and definition is therefore required.

Skills that should be removed…
None

**Dental Therapists**

9. **Is there anything that should be added to a dental therapist’s scope of practice?**
   No
   The list provided would appear to reflect the duties normally taught as part of a dental therapist’s initial training.

10. **Please identify anything that you would add to or remove from the proposed additional skills for dental therapists and give reasons.**
    **Skills that should be added…**

    As indicated previously DPL supports a competency based approach whereby the Dental professional can demonstrate appropriate training to support an area of practice. Please refer to the general comments made earlier in this submission particularly in relation to additional skills.

    In more specific terms:-

    There is no definition of the extraction of permanent teeth or how this procedure is carried out. In reality this could well involve quite extensive oral surgery or a surgical procedure. This would probably be beyond the normal skills taught to a therapist and would require extensive additional training. There are difficulties in the provision of such extractions where the ability to surgically remove the tooth is unavailable and for a therapist to undertake such a task without the necessary additional surgical skills might not be in the patients best interest.

    DPL would not however wish to suggest that attaining such skills would be beyond any therapist. Once again much will depend on the individual’s training and competency.

    **Skills that should be removed…**
    None

**Dental Technicians**

11. **Is there anything that should be added to a dental technician’s scope of practice?**
    No
    The list provided would appear to reflect the duties normally taught as part of a dental technician’s initial training.

12. **Please identify anything that you would add to or remove from the proposed additional skills for dental technicians and give reasons.**
Skills that should be added…

As indicated previously DPL supports a competency based approach whereby the Dental professional can demonstrate appropriate training to support an area of practice. Please refer to the general comments made earlier in this submission particularly in relation to additional skills.

Skills that should be removed…

It is not clear to DPL why it is to the benefit of the patient for a dental technician to undertake (rather than assist in):

a. the taking of impressions (other than those directly related to the repair of a denture).

b. the recording of occlusal registration (other than when directly related to the repair of a denture).

c. the taking and processing of radiographs.

d. the provision of tooth whitening to patients.

Bearing in mind that most dental technicians do not have close contact with patients and are only rarely involved in clinical procedures, expanding the duties of dental technicians in this way would seem to be moving a long way outside of their usual duties. The distinction between dental technicians and clinical dental technicians is reasonably clear at present, but these proposals would erode this clarity and increase the potential for confusion.

Clinical Dental Technicians

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<th>13.</th>
<th>Is there anything that should be added to a clinical dental technician’s scope of practice?</th>
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<td>No</td>
<td>The list provided would appear to reflect the duties normally taught as part of a clinical dental technician’s initial training.</td>
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<th>14.</th>
<th>Please identify anything that you would add to the proposed additional skills for clinical dental technicians and give reasons.</th>
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<td>Skills that should be added…</td>
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As indicated previously DPL supports a competency based approach whereby the Dental professional can demonstrate appropriate training to support an area of practice. Please refer to the general comments made earlier in this submission particularly in relation to additional skills.
In more specific terms:-

DPL receives enquiries on a regular basis from clinical dental technician (CDT) members in relation to the need for an oral assessment by a dentist prior to the provision of removable denture. It would appear that although CDTs are keen to comply with the GDC’s guidance and fully understand why an oral assessment from a dentist may be required for a dentate patient, this does place them in an extremely difficult ethical position.

In many cases patients who visit CDTs do so having already rejected mainstream dentistry for a variety of reasons (fear of dentists, past history, etc) and in those situations will refuse to see a dentist, irrespective of how persuasive the CDT is. This then leaves the CDT in a dilemma in that he or she must act in the best interests of the patient, but by refusing to provide treatment may well force that patient to seek treatment from an unregistered individual.

It is not clear why the GDC do not feel that the assessment of a dentate patient could not be undertaken by a competent CDT whose training reflects this skill. DPL’s thinking in this matter is expanded in question 19 below.

DPL would suggest that further consideration by the GDC is required to address this aspect.

The provision of a removable prosthesis, retained on existing implants can be an extremely complex restorative procedure and is often something that a general dental practitioner may not feel comfortable undertaking without additional training. DPL would endorse this view as being in the best interest of the patient and should not be one that is undertaken by a CDT unless they can demonstrate that they have obtained the necessary skills and competency.

Dentists

15. **Please identify anything that you would add to the proposed additional skills for dentists and give reasons.**

*Skills that should be added…*

As indicated previously DPL supports a competency based approach whereby the Dental professional can demonstrate appropriate training to support an area of practice. Please refer to the general comments made earlier in this submission particularly in relation to additional skills.

In more specific terms:-

DPL would agree that the provision of dental implants, together with the associated advanced surgical procedures (sinus lift, bone harvesting, etc) should not be one that is undertaken by a dentist unless they can demonstrate that they have obtained the necessary skills and competency through further training. The majority of dentists will not have had any experience of placing implants during their undergraduate dental training.
It is also DPL’s opinion that the teaching of sedation within the undergraduate curriculum although adequate, is not necessarily comprehensive and in many cases amounts to no more that an appreciation of the skill. It would seem logical to suggest that a dentist undertaking the various sedation techniques (particularly the advanced multi drug sedation techniques) should undertake additional training.

16. Having read the preface and the draft guidance on scope of practice, do you agree with the approach we have taken – of registrants using their skills within clear parameters?
Yes
If you do not agree, please explain why:

17. Do you think that issuing new standards guidance is the best way for to take this forward?
Yes
If no, what do you think would be a better way?

18. Should any DCP group be able to carry out tooth whitening using bleaching agents, on prescription from or under the supervision of a dentist?

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<th>Yes on prescription</th>
<th>Yes under supervision</th>
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<tr>
<td>Dental nurses</td>
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<td>Orthodontic therapists</td>
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<td>Dental hygienists</td>
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<td>Clinical dental technicians</td>
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Notwithstanding the issue of legality in respect of the prescription of hydrogen peroxide for the purposes of bleaching teeth, DPL has some difficulty in answering this question in the somewhat simplistic way in which it is presently formulated. In addition the question makes no distinction between the various tooth whitening techniques (home bleaching or in surgery power bleaching) which in themselves carry a differing level of risk and consequently a differing requirement for clinical skills in order to carry out the procedure safely and to an acceptable standard.

As indicated previously DPL supports a competency based approach whereby the Dental professional can demonstrate appropriate training to support an area of practice. Please refer to the general comments made earlier in this submission particularly in relation to additional skills.
There seems to be no reason why any registrant should not be permitted to whiten teeth using a bleaching agent irrespective of the technique undertaken or whether the technique is carried out on prescription or under supervision, provided the registrant is able to demonstrate the necessary training and skill required. It is the competency of the individual registrant that should be the main consideration.

DPL does however not understand why a dental technician would need to carry out tooth whitening within the context of their normal role. As previously indicated the skills of a dental technician are not clinically based and it is debatable how competency in the necessary clinical skills could be acquired without significant additional training. Should such training be attainable however there is no reason to exclude this DCP group.

| 19. | **In 2006, the Council decided that the only group of DCPs who could see patients who had not seen a dentist first were clinical dental technicians. They are allowed to see patients who have no teeth to provide them with full dentures. There is no plan to review that decision in the next 12 months. However, a new Council will take over in 2009 and we would like to help them decide what skills would be needed if training to allow other groups to see patients directly was to be proposed. What skills do you think would be needed to make direct access to DCPs safe and effective for patients?**  
Skills needed… |
|---|---|
| As indicated in the answer to question 14, DPL is aware of the difficulty that CDTs have in particular with the requirement of a patient to see a dentist where that patient is not edentulous. In addition, it is DPL’s experience that where other DCPs own and operate practices where no dentist is retained or present on the premises, similar difficulties are often experienced in obtaining an appropriate treatment plan from a registered dentist.  
As indicated previously DPL supports a competency based approach whereby the Dental professional can demonstrate appropriate training to support an area of practice. Please refer to the general comments made earlier in this submission particularly in relation to diagnosis and additional skills.  
This is a highly contentious area of debate and one that may need to be the subject of an additional consultation by the GDC. DPL supports the “gatekeeper” concept, at the heart of which lies the responsibility for case assessment, diagnosis and treatment planning, but it is for the GDC to decide the precise nature of the gatekeeper and to what extent this can and should be the role of the DCP. That role should not be restrictive and should reflect the competency, experience, training and skills of the individual. We believe that a competent DCP will be able to recognise a situation when there is a need to involve a colleague with a different set of skills and experience, in just the same way as a dentist is able to make such a decision when referring a patient for treatment by a specialist. Recognising the need to involve a colleague does not necessarily involve the DCP in making a diagnosis, but the DCP would still have performed a “gatekeeper” function. We believe that the nature of the gatekeeper role is an area of common and wide misconception. |
In order to be of assistance in this respect it may be advantageous to look at other professions where a similar difficulty has arisen. Looking, for example, at physiotherapists, the guidance produced by the Health Professionals Council (Standards of Proficiency November 2007) provides advice as to how physiotherapists are able to practice as autonomous professionals, exercising their own professional judgement (paragraph 1a.6). In effect, in working autonomously, a physiotherapist is required to know the limits of their practice and when to seek advice or refer to another professional. A similar situation could be considered for DCPs following consultation and refinement.

From DPL's point of view as a provider of indemnity to all members of the dental team, it is important to know the precise parameters under which a registrant undertakes a duty. Where diagnosis and treatment planning are concerned there are significant risk management factors that would affect the subscription a member might pay. Transparency and clarity is therefore important.

20. What should the GDC be saying to registrants about the following activities as legitimate additions to conventional dentistry?

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<tr>
<td>Dermal fillers such as collagen used in the face?</td>
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<tr>
<td>Dermal fillers such as collagen used in other parts of the body?</td>
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<tr>
<td>Botox when used in the face</td>
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<tr>
<td>Botox when used in other parts of the body?</td>
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<td>Bone Harvesting other than from the mouth?</td>
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It is not understood why other facial aesthetic techniques are not mentioned within this table (for example, dermabrasion, chemical peels, laser therapy and high energy wrinkle reduction therapies – all of which are known to be carried out by at least some dental registrants).

The use of Botox, dermal fillers and other techniques are now becoming more common within the profession either as a stand alone procedure or as an adjunctive procedure to other conventional dental treatment. That has however been considerable debate within the profession regarding whether or not these procedures represent the practice of dentistry or who should be permitted to carry them out. In addition as all dental registrants are required to maintain “adequate and appropriate” professional indemnity for their dental professional activities, there is a “grey area” in respect of whether this requirement for indemnity extends to those activities.

In terms of Botox and dermal fillers (including collagen replacement techniques) DPL believes that dental healthcare professionals are better placed, in many respects, than many other potential providers to carry out these procedures safely and successfully, not least because of their, particular range of background knowledge and training, the standards of infection control, and their ability to manage a medical emergency. The safety and welfare of patients should be the overriding consideration, and the patient’s right to choose what treatment they wish to receive, when, and from whom, is fundamental to patient autonomy.
DPL believes that bone harvesting outside of the mouth from the ribs and iliac crest are recognized procedures in oral and maxillofacial surgery practice and it is important that this review should not limit that technique to GMC registrants alone. The training required to undertake this procedure is rigorous and often includes a period of general surgical training that is not available to non-hospital based practitioners.

It is DPL’s view that if a registrant proposes to offer the activities listed above (the use of Botox, dermal fillers, collagen replacement therapy and bone harvesting) it is expected that the GDC will require them to be able to demonstrate that they have appropriate and sufficient training in order to be competent in the techniques proposed. In addition, as the use of these techniques often falls outside of the “normal” indemnity offered to dental registrants, it would be important for the clinician to demonstrate that the necessary indemnity is in place.

DPL believes that the present uncertainties and inconsistencies are unhelpful, particularly if it results in a situation where a patient cannot be compensated for a cosmetic or adjunctive procedure that results in a successful claim against a dental healthcare professional. A clear lead from the GDC perhaps as a result of this consultation would be beneficial.

What should the GDC be saying to registrants about complementary therapies and/or treatments (for example, acupuncture and hypnotherapy) which they provide but which are not linked to a patient’s dental treatment?

Certain complementary therapies and treatments have for some time been used by many dental practitioners as an adjunct or alternative to traditional dental treatment. The provision of complementary therapies however outside of that required by a patient as part of their dental treatment, is not something that should concern the GDC unless it can be shown that the clinician’s GDC registration in some way misleads the patient.

The use of acupuncture, for example, for the treatment of back pain may well be proficiently and appropriately undertaken by a registrant although it should be made clear to the patient that they are not acting in their capacity as a dental registrant, as it is not the practice of dentistry. Provided then the patient is aware of this fact, and the registrant has adequate and appropriate indemnity for the techniques used, then we see no reason for the GDC to become involved other than in the context of the general guidance in “Standards for Dental Professionals”.

Do you have any other comments on this part of the consultation? If they relate to a particular question, place state which one.

No

Do you agree with the policies regarding dental nurses in training?

No

If you do not agree, please explain why below…
Given the current problems experienced by trainee dental nurses in obtaining places on an approved training course, and the need for a dental nurse to undertake twenty-four months of chairside experience before full qualification is gained, there is always likely to be difficulties unless appropriate provision can be made.

It follows then that referring to a dental nurse as being “in training” seems a logical step. DPL would also agree that a named supervising registrant working within the practice should take responsibility for overseeing the dental nurse’s training and be accountable if required. DPL recognises that in some practices (particularly in single handed practice) that named registrant may be the dentist.

There is also difficulty in defining how long the “in training” period should reasonably last. The continuation of a dental nurse “in training” should have a finite period in order to be fair to the individuals concerned and for the protection of the public. This however should not be too rigorous in the interests of fairness and it may well be that the supervising registrant might need to offer a reasonable and appropriate explanation if the “in training” period could be regarded as excessive or overly long.

DPL would also agree as is the case for all team members, that the standards applicable to a dental nurse should also include a dental nurse “in training”, and it may well be that the supervising registrant would have the intimate responsibility.

24. **Do you agree with the policies regarding dental technicians in training?**
   
   No
   
   *If you do not agree, please explain why below…*

   DPL would refer the reader to the answer to question 23. The issues concerned are very similar.

   DPL also recognises the debate that is currently taking place in respect of the role of process workers with dental laboratories that is perhaps outside of the scope of this consultation.

25. **Do you agree with the policies regarding registered general nurses working in maxillofacial, oral surgery or orthodontic clinics in hospitals?**
   
   No
   
   *If you do not agree, please explain why below…*

   DPL would have difficulty with such a statement. Although it is accepted that NMC registered nurses are perfectly entitled to carry out certain “medical tasks”, it is difficult to see why the removal of sutures would be regarded in this respect. As indicated in the answer to question 4, DPL does not see any objection to a properly trained and competent dental nurse removing sutures. By definition therefore this then becomes a “dental task” under the Act.

   DPL would suggest that in order to comply with the relevant Acts that certain procedures could be best regarded as “medical and dental tasks”. To refer to some procedures that would often (but not exclusively) be carried out in an oral surgery department as being a “medical task” alone may be restrictive and misleading.
In addition, DPL cannot see what task could be carried out in a hospital orthodontic clinic that would not be regarded as the practice of dentistry. General medical nurses are not trained to undertake or assist with orthodontic procedures and there are unlikely to be any medical procedures that would normally be carried out in such a clinic. There is then a danger of the GDC being too prescriptive.

DPL would not suggest that a general medical nurse should not assist in orthodontic or oral surgical procedures provided that they have the relevant training, expertise and skills to do so. Once again then this is a matter of competency.

DPL would reiterate however that it is important that the general medical nurse should have suitable and appropriate indemnity.

26. **Do you agree with the policy regarding unregistered staff and others assisting in the absence of a dental nurse?**

No

*If you do not agree, please explain why below…*

It is DPL's opinion that such a policy may not be realistic, although it would endorse the view that registrants seeing patients whether within the surgery or in a domiciliary setting, should not routinely work without the assistance of a dental nurse or other suitably trained person.

There are however occasions, due to illness and sudden unexpected events that are beyond the control of the registrant. Such events may not necessarily be regarded as an emergency, more a fact of practice life. Standby arrangements may indeed be feasible, but not necessarily practical. Agencies providing registered staff are at the time of writing not that widespread and certainly in rural areas the availability of standby staff (who are available at extremely short-notice to travel and attend) may be nonexistent. In large cities this may not be a problem. It seems unreasonable therefore to put forward a policy, the effect of which would be to disadvantage one practice over another.

DPL would agree however that if no nursing assistance is available, then registrants should act in the best interests of the patient and decide whether to proceed. The GDC’s current guidance (Principles of Dental Team Working paragraph 3.7) makes it clear that a third party should be present in the room who is trained and able to assist in medical emergencies. By definition that third person may not necessarily have received the appropriate training to undertake the normal duties of a dental nurse.

There are however situations where such stringent application of policy may not act in the patient's best interests. It may be, for example, that part way through a procedure the dental nurse assisting the dentist or DCP becomes ill and is unable to continue. The clinician may feel that halting that patient’s treatment at that stage may be impossible, or outside the best interests of the patient.

It seems logical to suggest therefore, in the absence of any other dental nurses within the practice, that an unregistered third party be asked to assist (as a Good Samaritan) in order to complete or stabilise the patient's treatment. It follows then that the third party may only act as a dental nurse in a strict emergency where the treatment could not be curtailed. This would be regarded as an extremely rare situation.
27. **Do you agree with the policy regarding non-GDC registered healthcare professionals working in the mouth?**

   No

   *If you do not agree, please explain why below…*

   DPL would have no difficulty endorsing the use of suitably qualified and registered healthcare professionals taking whatever action is required to deal with a dental emergency. DPL however would not feel that this should be regarded as a “medical task” and, as indicated above (in question 25), it might best be regarded as a “medical and dental task”.

   DPL would also have difficulty in the wider context. The removal of a tooth, for example, as part of an osteotomy, would almost certainly be an elective procedure and the clinician concerned would need to demonstrate that they had the necessary training, expertise and skills in order to undertake this task competently.

   DPL notes that the extraction of teeth is not part of the normal medical curriculum and in general doctors are not specifically trained to extract teeth (even in an emergency). It is then difficult to see how this could be regarded as a “medical task”. Some doctors particularly those with a background of training in a hospital oral maxillofacial department may well possess the necessary competency.

   Again then it might be best to regard this as a “medical and dental task” in order to comply with the relevant Acts, and for the clinician concerned to demonstrate that they had suitable and appropriate training to undertake the procedure competently.

   Again DPL would reiterate that it is important that the clinician should have suitable and appropriate indemnity.

28. **Do you agree with the statement regarding student dental professionals providing dental nursing in practice?**

   Yes

   *If you do not agree, please explain why below…*

29. **Do you agree with the statement regarding the responsibilities of registrants who choose to send work to overseas laboratories?**

   Yes

   *If you do not agree, please explain why below…*

30. **Do you agree with the statement regarding full mouth assessments and treatment plans?**

   No

   *If you do not agree, please explain why below…*

   Please refer to question 14.

31. **Is there anything that should be added to the list regarding legal obligations?**
| 32. | Do you have any other comments on this part of the consultation? If they relate to a particular question, please state which tone. | No |