Practice Management Forum
Orthodontic Therapists—the current situation

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Abstract. *The promise of the U.K. being allowed to use auxilliary help in orthodontics is slowly gaining momentum. At long last, key factors are under discussion, such as permitted duties, length of training, etc. This article describes the present situation and highlights the disappointing rate of progress*

Index words: General Dental Council, Orthodontic Therapists, Professions Complimentary to Dentistry.

Introduction

The use of auxilliary personnel in dentistry is not new. In the USA, in the 1920s Dr Edmond Kells was the first to advertise that his practice had a 'lady in attendance to calm the nerves of protective family members unwilling to relinquish their wives and daughters to a strange man'. The American Dental Assistants Association (ADAA) was formed in 1924 and in 1933 *The Dental Assistant* was adopted as the official publication.

In the U.K. hygienists were first used in the WAAF in the Second World War in 1943. A certification was organized by the then Ministry of Health in 1949.

Therapists were trained at New Cross in the 1970s and were permitted to undertake certain clinical procedures such as infiltration local anaesthesia, extraction of deciduous teeth, and undertake simple dental fillings. They were only allowed to carry out such tasks in a hospital environment or in the Community Service. The dental profession and the public have therefore had a significant period of time to become accustomed to certain tasks being performed by auxilliary staff, and those personnel being supervised and regulated. It is worth noting that in the medical profession many important tasks are delegated to auxilliary staff—phlebotonists take blood samples, paramedics, not doctors, are the first personnel to tend emergency patients in the ambulance service, clinical nurse specialists give chemotherapy, put up drips, and take their own clinics. Orthodontic auxilliaries are already employed in two-thirds of European countries, the U.S.A., South Africa, and many other countries. The U.K. is lagging far behind the rest of the world in this respect.

It is therefore somewhat surprising that orthodontic auxilliary personnel have not been established in the U.K. especially given the huge workload, the shortage of orthodontists, and the uneven distribution of specialists.

The General Dental Council (GDC)

In 1996, the GDC set up the Dental Auxilliaries Committee to review the implementation of auxilliaries in many disciplines of dentistry, not just orthodontics. Dental technicians, clinical dental technicians, and maxillofacial prothetists and technologists were other groups being established. The term Professions Complementary to Dentistry (PCD) was to be the preferred title, rather than auxilliary.

Representatives of many concerned organisations were invited to give orthodontic input including the British Orthodontic Society BOS), the British Association of Dental Nurses (BADN), and the Orthodontic National Group of the BADN.

Meanwhile the Government had made changes which would enable the Secretary of State for health to amend the Dentist's Act by Order. Previously, the profession had been told that sufficient parliamentary time would not be likely to be forthcoming to enable any proposed changes to become law. Parliamentary time is still required, however, even with Order Making Powers.

Current Situation

The GDC have proposed the setting up of three Boards which would report directly to Council

Board A: dental hygienists, dental therapists, orthodontic therapists.
Board B: dental technicians, clinical dental technicians, maxillofacial prosthetists and technologists.
Board C: dental nurses.

There will be self-regulation for each group within each board. Initially, members will be nominated by existing members, but once legislation is in place membership will be by election.

Title

The title 'Orthodontic Therapist' has been chosen as the preferred name for orthodontic auxilliaries.

Permitted Duties

The GDC wish to get away from a prescriptive list of clinical functions which could delay participation of Orthodontic Therapists in unforeseen future developments in clinical practice. The GDC have approved the clinical procedures recommended in the report of the Auxilliaries Review Group' (Report of the General Dental Council Dental Auxilliaries review Group, 1998). This would include:

(1) the taking of impressions;
(2) the fitting of orthodontic bands;
(3) the placement of direct bonded attachments;
(4) the ligation of archwires;
(5) the removal of orthodontic bands and bonds.

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The GDC stress that 'the needs of the patient and the protection of the public are of paramount importance' and that the PCD 'would be required to operate under the direct personal supervision of a registered dentist who had previously examined the patient and provided a treatment plan'.

Areas of Concern

At the 1998 BOS Conference, during a debate on the subject of PCDs, the majority of the delegates left the then President of the GDC in no doubt that they felt that only those on the Specialist Orthodontic List should be allowed to use PCD's. The concern was that those dentists with insufficient skills in the use of fixed appliances may be tempted to employ PCD's, in which case the PCD could well have a greater knowledge than the supervising dentist and could be open to abuse. This was not felt to be acceptable to the speciality.

The Future

A 'Steering Group' will be set up, and within this steering group small working groups will be established to clearly define the curriculum and ethical guidelines. It is thought that each group of PCDs should share some parts of their curriculum particularly in the core basic sciences. Indications on the timescale for the introduction of orthodontic therapists is not yet forthcoming, but draft proposals were sent in January 2000 and the first meeting of the steering group will be in March 2000.

Outstanding Issues

1. *Length of training*. In the paper by Attack *et al*. (1999) it was suggested that following some pre-course remote/distance learning or introductory skills, 4 weeks of orthodontic skills training for qualified dental nurses would be sufficient. This training was divided into 17 modules (e.g. cross-infection control, ligation of archwires, etc.) it was suggested that this would be followed by a probationary period of 9 months working under supervision in a specialist practice. It is hoped that this model is followed and training is not extended unnecessarily.
2. *Funding*. It would be useful if the skills training could be centrally funded, as is currently the case with hospital training of dental nurses, hygienists, and therapists. If this funding is not forthcoming it is difficult to see how the whole project could succeed. The probationary period could be regarded as self-funding—the increased turnover in a practice supporting the supervision that would be required.
3. *Location*. If it is envisaged that the orthodontic skills training should take place in hospitals, the institutions willing to participate need to be established, staff organized, curriculum's agreed, and funding made available. In the U.S.A. there is a dual training pathway, with some trainees electing to train entirely in a specialist practice. This is termed 'on the job training' and both those that trained in hospitals and those that trained in specialist practice would sit a common examination on completion of training. If such training pathways have been long established and acceptable in such a litigious country as the U.S.A. there is no reason why the same model should not be acceptable in the U.K.

If on the job training is not to be, a day-release scheme would be extremely useful, not to say essential, if existing dental nurses currently working in orthodontic practices wish to gain the required expertise. Logistics and finance could well be insurmountable if it is envisaged that someone is to take several weeks off work, away from homes and family to attend a 4- or 6-week course. It would also be important that if hospitals were the only place of training, many geographically diverse centres were set up.

4. *Final examination*. It is debatable whether a final examination is necessary especially if each trainee were evaluated at the end of each module as envisaged in the study at Bristol. If a module were failed it should be repeated until a pass mark achieved. A pass mark on each module and the completion of the probationary period could be considered sufficient evidence of ability.
5. *NHS Fees*. There is considerable concern that an already worried Department of Health will not tolerate the inevitable increase in productivity and thus increased NHS spending. There is fear that some of the lowest orthodontic fees in the world will be driven even lower, or a system of rationing ('prioritization') set up. However, the precedent of hygienists working in the NHS and, fees not being cut, has already been established. Despite the recent significance rise in NHS orthodontic expenditure, the orthodontic budget is still only a relatively small part of the total NHS budget for dentistry. It should also be noted that despite being the fourth richest country in the world, our percentage of Gross Domestic Profit (GDP) spent on health overall is lamentably lagging far behind many of our neighbours!

Conclusions

The speed at which events are moving is painfully slow. it is now three-and-a-half years since the Auxilliaries Sub-committee was set up. The curriculum has yet to be decided, funding established, training centres approached, length of training decided, etc. By way of contrast the entire U.S. Constitution was written in 5 months in 1787!

Orthodontists in the U.K. have waited patiently for many years for the introduction of PCDs. It is clearly an inefficient use of scarce resources for a highly qualified orthodontist to spend a large part of their working day taking impressions or ligating archwires, etc.

The quality of care, if orthodontic therapists assist orthodontists, should improve, as perhaps greater time could be spent on diagnosis, and overall supervision and progress of treatment.

Just as importantly, the introduction of orthodontic therapists would develop a career pathway for those talented and enthusiastic dental nurses who currently are prevented from taking a full and active part in the treatment of those thousands of children in need of orthodontic treatment in the U.K. Not to use these skills does not make sense and it is hoped therefore that the introduction of orthodontic therapists proceeds speedily.

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