Health and Social Care Integration Directorate
Chief Dental Officer & Dentistry Division

The Scottish Government

To all Dental Practitioners

Dear Colleague

IR(ME)R

As you are aware Dr Arthur Johnston, Warranted Inspector for the Medical Exposure Regulations recently undertook a series of dental practice inspections relating to IR(ME)R.

In general the dental practices that had adopted and adapted the 'sample procedures' provided on the scottishdental.org website did well. For those practices that had not adopted these 'sample procedures' the level of compliance and of awareness of the duties on the employer was variable and, in some cases, poor.

There were three main areas where there appeared to be inconsistencies in approach; patient identification, pregnancy enquiry and assessment of patient dose for comparison with diagnostic reference levels (DRLs). Dr Johnston has proposed a pragmatic solution to these issues and I have agreed with his suggestions for a way forward.

Patient Identification

Regulations dictate that formal patient identification should be made prior to every exposure. This would seem unusual in a dental practice setting where the dentist often knows the patient and indeed may be undertaking treatment. However in order to comply with regulations, some identification should be undertaken. We suggest that the dentist should confirm that the correct casenotes for the patient are available, prior to exposure.

In dental practices where the radiographic exposure takes place away from the dental surgery and may be undertaken by another member of staff, then full identification should take place by confirming; name, address and date of birth.

From the
Chief Dental Officer
Margie Taylor MSc MBA
FDSRCSEd FDSRCPS(Glasg)
FFGDP(UK)

Telephone 0131 244 2302
Fax 0131 224 2621
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Addresses

For action
Chief Executives, NHS Boards
Dental Lead Officers

For information
Consultants in Dental Public Health
Clinical Directors of the salaried dental service
Directors of Public Health
Dental Practice Advisers

Enquiries to:

Dr Arthur Johnston
St Andrew's House
EDINBURGH
EH1 3DG

Tel: 0131 244 2779

INVESTOR IN PEOPLE

Pregnancy Enquiry

Dental radiography is considered low risk and enquiry regarding pregnancy is not routinely undertaken. However we believe that it would be helpful if a notice could be placed in the waiting area to inform women who are, or think they may be, pregnant that they should inform the dentist of this prior to any x-ray being taken. This would allow the dentist to discuss the issue with the patient who can be reassured that dental x-rays are low risk. This will allow fully informed consent for the radiographic procedure.

Dose Assessment

In large medical radiography departments, the dose achieved during exposure is measured each time. This is not feasible in a primary care dental practice setting.

I have agreed with Dr Johnston that within dental practice, in the absence of a means of routine dose monitoring during the period between these RPA assessments, pragmatic approach is required. Dentists can assume that, unless some difficulties emerge between RPA assessments, and provided that the selected exposure factors (kV, mA, and time of exposure) are unchanged, the latest of these RPA measurements shall remain valid as an ongoing assessment of patient dose. After seeking the views of RPAs around Scotland, the inspector has agreed a consensus position on DRLs and these are detailed below, however individual NHS Boards and dental practices may elect to set lower DRLs should they wish.

Tooth	Film and Computed Radiography		Direct Digital Radiography	
Mandibular Molar	Adult	2 mGy	Adult	1 mGy
	Child	1.2 mGy	Child	0.7 mGy

It is essential, therefore, that your RPA service provides clear and comprehensive patient dose assessment, in units that are directly comparable to local DRLs. I believe this is a sensible and balanced approach and I would be grateful if all dentists and dental practices implement these three changes with immediate effect. Additionally, the relevant Employer's Written Procedures should reflect these changes.

Further advice and sample templates can be found within the Practice Support Manual at www.psm.sdcep.org.uk and on www.scottishdental.org

Yours sincerely

Margie Taylor
Chief Dental Officer