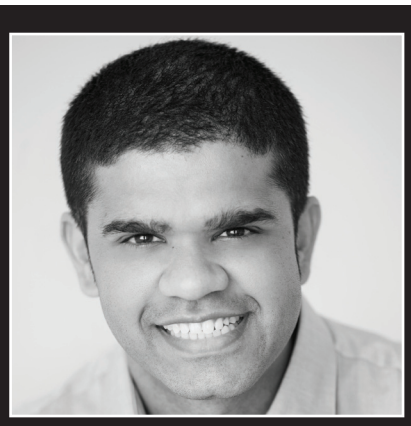

Time for dental schools to step into the 21st century, argues **DR NILESH R PARMAR**, one of the few dentists in the UK to have a degree from all three London dental schools...

I RECENTLY read an article stating that a 3D simulation model of a human head and neck, designed in Glasgow for NHS education in Scotland, is set to revolutionise medical and dental training, and this got me thinking about my own dental training and the curriculum in use today.

The curriculum in many dental schools hasn't changed since I qualified. The undergraduates are still being taught a type of dentistry, which is, arguably, perhaps not as relevant to what is practised today. If you think about it, are dental schools really preparing our future dentists for life in the big bad world of dentistry?

After speaking to a few recently qualified dentists from different dental schools, it seems that many of the skills dentists in general practice take for granted are still not taught in dental schools. For example, dental implants – my personal bugbear!

There is little, or no, dental implant teaching taking place in dental schools. Some students report a few lectures, but almost all of them have never seen an implant being placed during their undergraduate years, with little understanding for the referral criteria.

It would seem that dental implants is the only area of dentistry that is not covered at undergraduate level, and with this type of treatment becoming increasingly popular, surely it would make sense to train undergraduates in this discipline. I would hope that in the future, students are able to shadow postgraduate students, effectively acting as their dental nurses for a few weeks so they can see all of these advanced procedures taking place and aid their understanding.

Similarly, the cosmetic treatments of the moment, such as tooth whitening, short-term orthodontics and Inman Aligners, are not covered at undergraduate level, again suggesting that education and training provided at dental schools needs to step into the 21st century!

Furthermore, the business of dentistry and usage of the computer practice management systems should be covered. Surely just a few days' practise using EXACT or R4 is all that's needed for the young computer-savvy dental students to get to grips with such systems? I'm sure many would agree that this would make the transition into general practice all the more easier.

I feel it's time the curriculum for dental schools has more input from dentists in general practice. Perhaps we could provide a wish list of what skills we want our new VTs or dental graduates to have when they turn up on our doorstep asking for a job! ■

Building on Dr Nilesh R Parmar's *Viewpoint* on orthodontics last month, BACD Past-President, **DR TIF QURESHI**, gives his views...

GDP orthodontics is the hot topic of the moment – as highlighted by Nilesh last month.

I can only offer support to his comments, which is clearly echoed by the vast majority of the profession.

All GDPs have the ability and right to carry out orthodontics as long as they are working within their competence. However, there are valid arguments to both sides of the debate, especially when one considers how, with one orthodontic system, some inexperienced dentists carried out complex full mouth treatments, with apparently someone else taking responsibility.

Some of these treatments actually involved several extractions and then, all of a sudden, that company went out of business, and these dentists were left stranded. I have heard of one dentist with 60 cases either mid-treatment or about to start.

Even as a GDP very experienced in orthodontics, I would have not touched many of these cases myself – there are simply some things your average GDP should do and some we should not.

Of course, there are some highly capable GDPs out there with long-term experience in full-mouth, fixed orthodontics. Most GDPs stick to anterior, aesthetic orthodontics.

I would also argue that, as GDPs, we really need to be a little more analytical than is currently evident. Several years of specialist training will hopefully put you in the position to be able to judge space requirements in a variety of cases. As GDPs, it is essential that if we are carrying out orthodontics, our arch and space planning is faultless. I don't believe this is the case. Too many dentists pass the buck and want their technician or even a specialist to decide for them.

From the start, in a simple anterior ortho case especially, we should be in control of the anterior tooth position. No one is better than a restorative dentist to understand the importance of anterior position in relation to function, guidance and aesthetics. With simple anterior ortho of many varieties, it should be possible to plot a curve that the technician uses as a prescription for the occlusion, and to calculate the amount of physical crowding.

It is so important to know this figure because it closely relates to the amount of IPR that might be needed. Without it, you are guessing and, unsurprisingly, many cases are over expanded and lose guidance, or over stripped and then the teeth are retracted to close the space down.

By knowing exactly how much crowding there is, via Hanchers technique or using simple digital software, that crowding figure can be calculated, then the IPR carried out in a progressive measured way. It, critically, can also be the difference between knowing if a tooth needs extracting or not.

This way, you are in control of the case, not a technician or, indeed, anyone who says they are going to be responsible, because if things go wrong, they are not; you are and always will be.

Remember, use whatever mentoring is available, plan your cases carefully, but, most of all, work within your competence. ■

DR PETER BATEMAN, Chair of the BDA's Salaried Dentist's Committee, looks at community dentistry...

COMMUNITY dentistry has, for too long, faced challenges around its position in the dental family. It has been subject to so-called cost improvement programmes for most of the last 15 years, and, in some NHS trusts, also to more severe cuts as part of a cost-cutting exercise. Lacking adequate staffing levels, and, in some services, appropriate clinical leadership, it continues to support the rest of the dental family by providing primary and secondary care to those who cannot be treated in the mainstream service. It is a fact that the whole profession relies on these services to meet the requirements of a cohort of patients who will always have a complex range of needs, but will never be in a position to make their treatment requirements clear themselves; that must be done on their behalf.

There are testing times on the horizon, with more people living longer and an increasing number living with long-term illness, impairment and disability, meaning society's most vulnerable patients is a growing cohort.

The BDA's report, Commissioning salaried primary dental services for vulnerable adults and children: a vision for the future*, was published on April 23. Based on serious concerns identified by salaried dentists in a BDA survey last year, it makes a series of recommendations around budget, workforce planning and commissioning for NHS England to take on board.*

At the Accredited Representatives Conference*, which took place in London the day after it was published, delegates again echoed concerns they had first articulated in 2011. They reiterated their demand that clinical needs should be the most important factor in the commissioning and delivery of salaried dental services if the most vulnerable in society are to be accorded the same rights of access to oral health as the rest of the population.*

The announcement at the British Dental Conference and Exhibition later that week by the health minister, Lord Howe, that NHS England has launched a Task Group to look at how dental services could be improved for vulnerable patients, could not have come too soon.

We are looking to the Task Group to take a major leap in its assessment and make proposals for what needs to be done. We are hopeful, not least because it is being led by Dr Janet Clarke, a salaried services colleague and a former BDA President with considerable experience in managing dental services for these client groups.

In addition, the contract pilots now include three salaried sites and are developing new principles to move away from inappropriate targets and remuneration and allow services to treat patients according to their needs.

So, there are positive signs that the needs of the client groups, traditionally under the care of salaried dental services, are finally being recognised. The BDA is committed to working with NHS England to achieve the vision for community dentistry that comes with intelligent commissioning and design and implementation that works for the patients who need it most. ■