Decisions in Postgraduate Education: Community Dental Practice

DAVID J. WATSON AND ALLAN J. RENNIE

Abstract: **Since its inception, the Community Dental Service has evolved from a child-centred organization to its much wider remit of current times. This article reviews the present role of the CDS, examines the type of people who make up the workforce and considers what a career in community dental practice can offer to new or recent graduates. Specialization in community or special needs dentistry is not an option at the moment. However, a number of appropriate training opportunities leading to further qualifications are highlighted and are becoming more readily accessible.**

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Clinical Relevance: **Clinicians working in the CDS have to acquire and apply a range of patient management skills, which can be developed and enhanced through postgraduate training.**

As a career option, community dental practice can offer a dynamic, challenging and fulfilling alternative for recent graduates wishing to develop their skills towards the dental care of people who, for a variety of reasons, find it difficult to access care provision conventionally through the General Dental Service.

In England, the publication of Health Circular (89)2, *The Future Role of the Community Dental Service*,[1] in 1989, with equivalent documents for other UK countries, outlined the remit of the Community Dental Service at the time. This Department of Health Guidance was updated in 1997, focusing the attention of the CDS on its public health and clinical duties. In respect of public health, the CDS is expected to provide the following:

- oral health promotion programmes;
- oral screening for children at least three times in each child's school life;
- to screen other client groups with particular special needs; and
- to assist in local health authority service planning and national surveys of dental health through the provision of epidemiological fieldwork.

Clinical duties include the provision of oral healthcare for people who have found difficulty accessing such care in the General Dental Service, which may include young children and patients with special needs, together with the widely interpreted 'safety-net' function. Additionally, the Community Dental Service is required to provide treatment which is not generally available in practice, for example, general anaesthesia, sedation and, in some areas, orthodontics.

The dramatic changes which have occurred in the last decade have seen the emergence of a CDS with a role complementary to the primary care function of the General Dental Service. Much political commentary has accompanied the transition away from being a child-centred organization to a service which can provide good quality care for a whole range of somehow disadvantaged people who access their dental care through the CDS.

At present, career progression in the CDS is less well defined than it is in the hospital service. Following Vocational Training or on-the-job training as a Community Dental Officer, in order to progress to senior positions in the service, either clinical or managerial, it is generally necessary to acquire 'higher qualifications'. Attaining such qualifications may often be self-directed, with or without support from the employing Trust. As an increasing number of graduates have the chance to experience community dental practice through General Professional Training (GPT), it is necessary to provide them with further training opportunities in the shape of formalized training pathways which will enable them to provide the best possible care for people with special needs, enhance motivation and better their chances of career progression within the service. Future recruitment and retention of staff may well depend upon this development. Indeed, the executive of the BASCD Section in Clinical Community Dentistry believes that the only way to progress is

***David J. Watson**, BDS, DDPH RCS(Eng.), MSc, Senior Dental Officer, Greenock Health Centre and **Allan J. Rennie**, BDS, General Professional Trainee, Greenock Health Centre (August 2001–August 2002)*

Deanery	CDS Training Posts 2001 / 2002	CDS Training Posts 2002 / 2003	MFDS Accredited CDS Training Posts 2001 / 2002	MFDS Accredited CDS Training Posts 2002 / 2003
Northern	No Response			
Yorkshire	1	1	1	1
Trent	1	1	0	Awaiting approval
Anglia	0	1 CDS 1 CDS/PDS	0	0
London (previously North Thames)	Data unavailable due to recent changes in geographic boundaries			
Kent, Surrey, Sussex (previously South Thames)	6	7	4	5
Wessex	2	2	2	2
Oxford	3	3	0	2
South Western	2 CDS/PDS	2 CDS/PDS	0	0
West Midlands	1	1	0	0
Mersey	1	0	0	0
North Western	3	3	3	3
Northern Ireland	No Response			
Wales	3	5	3	3 (awaiting approval for 2)
Scotland	12	20	12	20

Table 1. *CDS involvement in VT/GPT by Deanery.*

to move towards specialist training of similar duration to that of other specialties, leading to a Certificate of Completion of Specialist Training in special care dentistry.[2]

THE CURRENT WORKFORCE

In comparison with the GDS, a relatively small number of dentists are employed in the CDS. In Scotland, for example, the ratio is twenty-five to less than three.

A comprehensive study,[3] carried out by postal questionnaire to all clinical dental service managers in the United Kingdom, with a 99% response rate, profiled dentists working in the CDS in terms of gender, job status, qualifications and clinical service provision. Out of a total of under 1600 dentists, the study elicited that a higher proportion of community dental staff were women (67.5%) and that women were also more likely to work part-time (60.5%). A higher proportion of men occupied Dental Services Manager or equivalent grade (14.4%) when compared with women (6.1%). Similar gender comparisons could be made in the proportions of males and females in clinical grades; a relatively higher proportion of men held Senior Dental Officer posts and a relatively higher proportion of women held Community Dental Officer posts. Possession of a postgraduate qualification was found to be quite common and linked to job status. Masters degrees were most popular. A total of 50.7% of men compared with 40.7% of women held an extra qualification. The range of clinical services offered was very varied, but centred on the care of vulnerable groups within society.

Recent Scottish data[4] show that the number of dentists employed in the CDS has remained relatively constant between 1992 and 2000, averaging 290 out of an NHS dental workforce of 2,500 in Scotland. The same report highlights some interesting comparisons with reference to where those dentists, who had undertaken Vocational Training in Scotland, were employed in each of the eight years after training. Unsurprisingly, the majority continued to work in the General Dental Service. The percentage of VTs working in the HDS gradually decreased from 8% one year after training to 3% eight years after training. The percentage working in the CDS increased from 2% one year after training to 7% eight years after training. Again, a gender trend is demonstrated. As time elapsed, the VTs who joined the CDS were predominantly female; the percentage rising from 3% to 13% between one year and eight years after training.

The dental workforce is supplemented by Professionals Complementary to Dentistry, who deliver and support oral healthcare services in a variety of settings, including:

- primary dental care;
- dental teaching hospitals;
- acute hospitals; and
- private businesses.

Community dental practice relies heavily on the support of hygienists, therapists, nurses, technicians, oral health promoters and dental health educators. In Scotland alone, there are an estimated 5,500 PCDs working in all branches of dentistry.[5]

GENERAL PROFESSIONAL TRAINING

Twelve months of Vocational Training is

Course Title	Location	Components	Period	Entry Requirements	Fees	Outline
Diploma in Special Care Dentistry	Royal College of Surgeons of England	Parts A and B examination	Must complete Part A – maximum 3 years Part B – maximum 5 years	Part A – dental qualification Part B – 2 years experience in special care dentistry	To be confirmed	Part A – completion of modular assignments Self-directed learning Part B – multi-faceted examination
Diploma of Membership in Clinical Community Dentistry	Royal College of Physicians and Surgeons of Glasgow Royal College of Surgeons of England	Parts I and II examination	No limit but must complete Part II within 5 years of Part I	4 years postgraduate experience with at least 3 years in a public dental service (not including VT year)	Part I - £220 Part II - £300	Oral disease diagnosis, treatment planning, specific treatment and follow up. Basic medical and dental sciences Health & Safety Organization of the CDS
Diploma of Membership in Special Needs Dentistry	Royal College of Surgeons of Edinburgh	Parts I and II examination	No limit but training post should not normally exceed 6 years	Part I – minimum of 2 years postgraduate experience in more than one clinical dental discipline Part II – minimum of 3 years spent in an approved post	Part I - £220 Part II - £385	Part I - basic applied dental sciences relating to special needs dentistry Part II - principles and practice of special needs dentistry

***Table 2**. Royal College postgraduate qualifications in community and special needs dentistry.*

mandatory throughout the UK for newly qualified graduates. In recent years, an increasing number of final year dental students have opted instead for a two year General Professional Training (GPT). There is no set structure for GPT and the schemes vary greatly in each postgraduate deanery.

Many schemes comprise a first year of experience in general dental practice as a Vocational Trainee, followed by a second year as a Senior House Officer in hospital or a Community Dental Officer in the CDS. There are also hybrid posts (e.g. in the East of Scotland and in the North Western Deanery) which offer six months in the CDS and six months in the HDS as part of the second year of training.

GPT gives recent graduates the chance to gain a wider experience of clinical dentistry without any financial pressure, as the entire 24-month period is salaried. It also gives insight into more than one type of service provision, better preparing a trainee to decide upon a future career pathway.[6]

A postal questionnaire was sent to each of the 15 postgraduate Dental Deans in the UK in June 2002. Thirteen responses were received by August 2002. The data gathered about CDS involvement in Vocational Training/ General Professional Training Schemes in the deaneries are shown in Table 1.

Many second year GPT posts, whether in the CDS or hospital service, are accredited for the MFDS examination. Only after completion of one year in an accredited post, and successfully passing Part A, can a candidate sit Parts B and C of the examination.[7]

The MFDS is an acceptable entry qualification to specialist training. Below is a list of established dental specialties in which a CCST may be obtained:[8]

- Dental Public Health
- Endodontics
- Orthodontics
- Oral Surgery
- Paediatric Dentistry
- Periodontics
- Prosthodontics
- Restorative Dentistry
- Surgical Dentistry
- Oral Microbiology
- Oral Pathology
- Dental and Maxillofacial Radiology.

As highlighted earlier, special care dentistry does not feature in the list.

All MFDS accredited CDS posts have the same 30 days study leave entitlement as SHO posts in hospital and, like VT posts in the GDS, also require attendance at core study days. Completion of a logbook and a weekly tutorial from the designated Community trainer supplement the educational components.

Trainees in the CDS can expect to further their experience in all aspects of clinical dentistry, although individual posts may vary dependent upon local treatment need and available facilities.

In particular, they can expect to extend their knowledge of:

- Oral care provision for patients with special needs;
- Medically compromising conditions which influence dental care;
- Paediatric dentistry;
- Gerodontology;
- Oral Health Promotion and Prevention;
- Epidemiology and Screening;
- Domiciliary care;
- Psychological aspects of behaviour management and dealing with anxiety;
- Pharmacological aspects of behaviour management including oral, inhalational and intravenous sedation and general anaesthesia.

POSTGRADUATE TRAINING OPPORTUNITIES AND FURTHER QUALIFICATIONS

In a paper examining the present and future role of community dental

services, Gelbier (1998) considers that one of the influential factors in future service development will be the outcome of alternative methods of service delivery, such as the PDS pilot studies.[9]

He envisages replacement of senior dental officers by appropriately trained and qualified specialists in community dental practice. The current lack of specialty status has been recognized as a problem not only in the United Kingdom, but also in Europe, Australia, New Zealand, the United States and Canada.[10]

Table 2 shows a selection of Royal College postgraduate qualifications in community and special needs dentistry. The MFDS is not an essential entry requirement, but often enables exemptions from certain aspects and is recommended for anyone hoping to gain entry to a specialist list, should it materialize.

The MCCD is mentioned but has declined in popularity. It continues to be available from the RCPS (Glasgow), but the last sitting in RCS (Eng.) was in March 2002.

Several universities are now offering Masters programmes in subjects such as special needs dentistry, sedation and special care dentistry, community dental health, community dental practice, dental public health and dental primary care. A flexible approach improves access to these courses as not all of them involve full-time study. Some of the qualifications may be attained through part-time attendance or study by distance learning, thereby alleviating financial pressure on potential candidates. However, all of the training programmes involve a substantial time commitment which is a consideration when balanced against full- or part-time employment and family life. Entry and attendance requirements, fees and further details can be obtained from the prospectus provided by the individual institutions. Most of the courses are quite widely advertised in the dental literature.

Finally, not all community practitioners wish to pursue a career which pertains entirely to special care dentistry. Community Dental Service management and the public health functions require expertise in planning and strategy development, health service economics and politics, employment law and human resource issues. A business qualification would not be inappropriate.

The potential for diversity in training and self-development begins to seem endless.

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ABSTRACT

DO PATIENTS APPRECIATE THE TRUE COST OF 'WHITE FILLINGS'?

Long-term Cost of Direct Class II Molar Restorations. P. Sjögren and A. Halling. *Swedish Dental Journal* 2002; **26:** 107–114.

It is probably well known that amalgam restorations have a longer prognosis than composite and glass ionomer. Indeed, much research on this subject has been generated from the Nordic countries, and has been referred to previously in these abstracts. Patients informed of the higher initial cost of a 'white' filling often fail to grasp the true perspective of this shorter lifespan of their restorations. Furthermore, the figures presented in this paper may be of considerable interest to third party providers of the costs of restorative care.

The authors report a previous investigation showing the mean survival times of Class II molar restorations to be 9.3 years for amalgam, 4.7 years for composite and 3.0 years for glass ionomer. They also give the average initial costs for these restorations, showing glass ionomer to be the cheapest and composite the most expensive. These figures are then mathematically extrapolated in a cost-analysis over time and related to both patient charges and the cost to the Swedish Insurance scheme. It is reported that, whilst environmental concerns would wish to reduce the use of amalgam, glass ionomer as an alternative may initially be cheaper but, due to the short lifespan, the long-term costs are significantly higher. The long-term costs for composite are exponentially higher, and may give cause for concern amongst third party insurance companies.

A complicated paper to read, but one with a profound message for practitioners.

Peter Carrotte
Glasgow Dental School