A survey of the quality and quantity of Special Care Dentistry teaching, including Gerodontology, in dental schools of the United Kingdom and Ireland

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Abstract

Aim and objectives: To investigate the Special Care Dentistry educational programmes in undergraduate dental schools of the UK and Ireland, and establish whether courses are adequate in fulfilling the learning outcomes in the General Dental Council (GDC) document ‘The First Five Years – A Framework for Undergraduate Dental Education’ and statements made by the Quality Assurance Agency (QAA) for Higher Education ‘Benchmarking Academic Standards: Dentistry’.

Design: A postal questionnaire survey of 15 dental schools across the UK and Republic of Ireland. Questionnaires were distributed to 1,220 final year students and 15 staff who co-ordinate Special Care Dentistry teaching at each school. The questions explored areas such as teaching methodology and student’s clinical confidence with Special Care patients.

Results: Ten dental schools returned student questionnaires and nine returned staff questionnaires. Most did not fulfil GDC or QAA requirements. The amount of didactic teaching and clinical experience varied considerably. Many undergraduates felt they did not receive adequate teaching and 87.9% did not gain sufficient clinical experience. Undergraduates felt ill prepared to treat certain groups of Special Care patients, especially those with mental health problems. Of the students who considered they had enough hands-on experience, only 22.9% felt ‘confident’ to carry out treatment.

Conclusions: The requirements of the GDC and the QAA are not being met. More clinical experience is required in most dental schools whilst in some schools, undergraduates receive none. Special Care patients are increasingly dentally motivated and many dental undergraduates are not adequately prepared in skills or attitude to provide high quality care.

Introduction

There are currently 8.6 million registered disabled people in the United Kingdom (Disability Rights Commission, 2006). However, reports have indicated that dental graduates and indeed, experienced dental surgeons, often do not have the expected confidence levels required for the management of such patients (Matthews et al. 1993; Wilson 1992). Prior to the emergence of Special Care Dentistry as a post-graduate speciality, the General Dental Council (GDC) stated in its document, ‘The First Five Years – A Framework for Undergraduate Dental Education’ (TFFY), that dental undergraduates should ‘gain an awareness of treating medically and physically compromised patients’ and ‘provide appropriate care for vulnerable people’ (General Dental Council, 2002). Special Care Dentistry has been defined in broad terms as: ‘The improvement of oral health of individuals and groups in society who have a physical, sensory, intellectual, mental, medical, emotional or social impairment or disability or, more often, a combination of a number of these factors’ (British Society for Disability and Oral Health, 2003).

Despite a paucity of information on teaching in Special Care Dentistry, Miller and Heil (1976) highlighted that delivery of a Special Care course should promote and foster a positive attitude towards these patients. Fur-
thermore, Gurney and Alcorn (1979) suggested that a positive attitude towards Special Care patients was influenced by exposure to their treatment during undergraduate training. A study by Wilson in 1992 demonstrated that Special Care Dentistry training has ‘A low priority in many dental schools’, and highlighted that, ‘Professional attitudes towards handicapped people, and willingness to treat them’ improved following teaching in this area.

Matthews et al. (1993) investigated dental graduate confidence levels in a number of subject areas, including Special Care Dentistry, and concluded that Special Care patients ‘Would not be managed confidently by most respondents’ and that undergraduate teaching in Special Care Dentistry teaching may not adequately prepare graduates for treating patients in primary care. The Working Group for Special Care Dentistry, established by the Dean of the Faculty of Dental Surgery at the Royal College of Surgeons of England, promoted the establishment of ‘A structured programme of education and training in Special Care Dentistry; thus equipping dentists with the appropriate knowledge, attitude and skills in this field’ (Thompson et al., 2001).

It is questionable whether the Special Care Dentistry teaching currently received by dental undergraduates is adequate to let them fulfil their duty of care towards these patients. Consequently, the aim of this study was to ascertain whether current, final year dental students and Special Care Dentistry teaching staff felt that the Special Care curriculum at their dental school met the learning outcomes of the General Dental Council’s ‘The First Five Years – A Framework for Undergraduate Dental Education’ (General Dental Council, 2002) and Quality Assurance Agency (QAA) for Higher Education ‘Benchmarking Academic Standards: Dentistry’ (2002). The survey referred to clinical and didactic teaching and sought to identify any barriers to teaching Special Care Dentistry in dental schools. Additionally, in the light of the development of Special Care Dentistry as a post-graduate speciality, this study investigated the extent to which the undergraduate courses encouraged students to pursue a career in Special Care Dentistry.

The General Dental Council encourages undergraduates to have knowledge of the ‘presentation of oral and dental diseases and disorders in elderly people…’ (General Dental Council 2002). Further recommendations have been made for improvement in education and training in Meeting the Challenges of Oral Health for Older people: A Strategic Review (Gerodontology Association, 2005). The Strategic Review recommended that ‘the GDC should amend its learning outcomes in ‘The First Five Years- A Framework for Undergraduate Dental Education’ specific to care of the older population including frail, older people’ and ‘the Council of Dental Deans should ensure that there is adequate expertise available within their schools to deliver the necessary education in Gerodontology at both undergraduate and at postgraduate level’. Consequently, Gerodontology teaching was included in this study.

Materials and methods

Following ethical approval from the Cardiff University Medical / Dental School Research Ethics Committee, a postal questionnaire survey was conducted between November 2006 and February 2007. Two versions of the questionnaire were sent to the fifteen dental schools in the United Kingdom (UK) and the Republic of Ireland. One version was circulated to the member of staff responsible for co-ordinating Special Care Dentistry teaching at the 15 dental schools, identified by their membership of the Teachers Group of the British Society for Disability and Oral Health, whilst the other was to be distributed by the course coordinator to 1,220 final year students. Both questionnaires were accompanied by a sheet informing participants of the nature of the study and why they had been chosen to contribute. This sheet also provided them with contact details for further information, as well as assurance about anonymity and confidentiality. A post-age-paid envelope was included with the questionnaires to encourage their return.

Questionnaire structure

Staff questionnaire

The staff questionnaire aimed to ascertain respondent’s opinions about the quality of Special Care Dentistry teaching, including Gerodontology, at their dental school, with reference to The First Five Years (General Dental Council, 2002) and the QAA benchmarking statements (Quality Assurance Agency, 2002). Recipients were also invited to give suggestions for improvements to this area of the undergraduate course.

Question topics included: the university departments responsible for teaching Special Care Dentistry (SCD); the configuration of this teaching (academic years when teaching is delivered, the location and duration of the course and the format of the teaching, e.g. lectures, seminars, community outreach attachments); whether Gerodontology was included in SCD teaching; how student knowledge and competency in SCD was assessed (e.g. formative assessment via class written tests, OSCEs, reflective logbooks, summative assessment); and finally, suggestions for improvements that could be made to the SCD course.

Final year student questionnaire

The purpose of the questionnaire directed at final year dental students was to gauge undergraduates’ confidence in managing Special Care patients following completion of the relevant part of the syllabus at their dental school. This questionnaire also aimed to assess the number of
dental students with an interest in pursuing SCD as a post-graduate speciality.

Question topics included respondents’ views on the adequacy of SCD teaching and whether they required more clinical experience in the subject. There were also questions to gauge confidence in carrying out dental treatment and to assess communication skills when dealing with Special Care patients. Students were asked if they had enjoyed SCD teaching and clinical experience. In addition, they were asked whether they would consider further training in SCD at post-graduate level.

Both groups of questionnaires were designed to be clear and succinct in order to address the common problem of non-response resulting from overly complex questions (Oppenheim, 1992). The questionnaires were coded to enable anonymous display of results, so no dental school or individual would be identified. Two mail shots were carried out at monthly intervals to ensure maximum response rates.

Results

Overall, ten of the fifteen dental schools returned student questionnaires culminating in 297 student responses (24%). Whilst nine schools returned the staff questionnaire, a response rate of 60%.

Responses to staff questionnaire: Form and amount of teaching

The main departments which had responsibility for Special Care teaching were Restorative clinics, Sedation Units, Paediatric clinics and Oral Surgery clinics. Teaching in most dental schools began in Year 3. Interestingly, only one school, (O) provided presentations from a disability equality trainer.

Most staff stated that the majority of Special Care teaching took the form of lectures, although this is not wholly supported by the data recorded in Table 1 where it appears that some schools provided more hours of hands-on experience than lectures. Nonetheless, four schools recorded that no hands on experience was provided. In contrast, schools M, N and O reported 54 hours, 12 hours and 30 hours of practical experience, respectively. Similarly, the number of hours dedicated to lectures at each participating dental school ranged from as little as 2 to 49 hours. All responding dental schools indicated that the students received some hours of teaching, but a number of staff members were not specific as to the amount. Therefore, it was impossible to gain a mean number of hours for the various methods of teaching delivery. This was especially true when only nine of the fifteen dental schools returned staff questionnaires. Overall, an accurate reflection of the amount of teaching in all dental schools could not be gained.

Gerodontology teaching

Gerodontology was included in SCD teaching at six of the nine responding dental schools. At the remaining three schools, experience was gained elsewhere in the curriculum; for example, school C asserted that ‘approximately 60% of patients seen by students are over 65’.

Did staff feel their school was meeting the requirements of the GDC and QAA?

Seven (78%) responded negatively to the question ‘Are you satisfied that Special Care Dentistry teaching at your Dental School is meeting the learning outcomes defined by the GDC (2002) and QAA (2002)?’. There were no qualifying responses where a participant selected ‘Yes’ for ‘The First Five Years’ and ‘No’ for QAA or vice versa.

Table 1

Delivery of teaching in Special Care Dentistry across the nine responding dental schools. Total hours over years 3, 4 and 5 (Staff Questionnaire).

<table>
<thead>
<tr>
<th>School</th>
<th>Lectures</th>
<th>Seminars</th>
<th>Hands on</th>
<th>Observation</th>
<th>Outreach</th>
<th>PBL</th>
<th>Equality training</th>
</tr>
</thead>
<tbody>
<tr>
<td>C</td>
<td>49</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>D</td>
<td>8</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>F</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>0</td>
</tr>
<tr>
<td>K</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>M</td>
<td>10</td>
<td>10</td>
<td>54</td>
<td>0</td>
<td>20</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>N</td>
<td>3</td>
<td>12</td>
<td>12</td>
<td>6</td>
<td>6</td>
<td>12</td>
<td>0</td>
</tr>
<tr>
<td>O</td>
<td>12</td>
<td>5</td>
<td>30</td>
<td>0</td>
<td>10</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>92</td>
<td>27</td>
<td>96</td>
<td>6</td>
<td>36</td>
<td>12</td>
<td>3</td>
</tr>
</tbody>
</table>
Assessment of knowledge and competence

At two dental schools, student knowledge and clinical competence were not formally assessed, but those schools examining these areas favoured summative assessment, whilst OSCEs were also popular. Generally, undergraduate reflective logbooks and projects were used for assessment of student knowledge and attitudes, rather than assessment of practical clinical skills.

Responses to open-ended questions

The final questions in the staff questionnaire allowed open comment about the Special Care course at each dental school and gave staff members the opportunity to suggest improvements. A number of participants emphasised the undergraduates’ need for ‘More hands-on experience’ and thought this could be facilitated by students ‘Integrating with Dental Care Professionals especially dental nurses with a National Examining Board Dental Nursing Special Care certificate’. Dental schools B and H commented that the SCD course ‘Should be more formalised’ and ‘Acknowledged separately’. One participant highlighted that ‘The present difficulty is that few consultants or academics…at the dental school…have a background in the subject’ and school M suggested there should be ‘Appointment of specialists in SCD’ to deliver the course. Finally, school B reiterated the lack of sufficient hands-on experience, which was a recurrent theme across all the participating dental schools, stating that currently SCD teaching ‘Offers little more than awareness raising’.

Responses to student questionnaire: Adequacy of teaching and hands-on experience

In response to the question ‘Do you feel you received adequate teaching on Special Care Dentistry?’ 63% (178) of 297 respondents said ‘No’. In addition, 68.4% (203) would have liked to have had more teaching in this subject area. Similarly, when asked ‘Do you feel you gained enough clinical experience treating Special Care patients?’ 87.9% of respondents stated ‘No’. Furthermore, 83.8% indicated they would have preferred more clinical experience with these patients.

Student confidence

Figures 1 and 2 present responses to the questions; ‘How confident do you feel carrying out dental treatment for Special Care patients?’ and ‘How would you rate your communication skills when dealing with Special Care patients, in relation to six categories of special care patient group. Most students selected the ‘Quite confident’ option when responding to the ‘Overall’ sub-question for both these main questions (60.3% [179] and 65.7% [195], respectively). Students felt most confident when treating older patients (confident = 26.9%, n=80) but were least confident undertaking treatment for patients with mental health problems (confident = 6.1%, n=18). Similarly, students lacked confidence when communicating with patients with mental health problems (not at all confident = 33.7%, n=100) and were more confident when communicating with frail older patients (not at all confident = 4.4%, n=13).

Students’ experience of SCD teaching and clinical experience

The study showed that 69% (205) of undergraduates felt their experience of SCD teaching was positive and 59.3% (176) enjoyed treating Special Care patients. However, this latter question produced the greatest number of non-responses (21.5%, n=64) with the majority of these students commenting that they ‘have not treated any’. This highlights that in some dental schools a number of students are receiving no hands-on experience with Special Care patients.

Eighty-one (27.3%) of undergraduates considered studying SCD at post-graduate level and 71.6% (58) of these students stated that they had enjoyed the clinical experience they had gained with Special Care patients.

Comparison of perceived course adequacy and student clinical confidence

Of those undergraduates who felt that there was adequate Special Care teaching at their dental school (36.9%, n=104), only 8.7% (9) were ‘Confident’ when treating such patients (Table 2). Additionally, of those who thought the amount of clinical experience gained was acceptable (12.4%, n=35), 22.9% (8) felt ‘Confident’ when performing treatment for SCD patients (Table 3). In contrast, of the undergraduates who did not think they had gained enough hands-on experience (87.6%, n=247), only 3.2% (8) felt ‘Confident’.

It appears that, of the participants who thought they had gained a satisfactory amount of practical experience, 68.6% (24) of them felt ‘Quite confident’ in their clinical ability with Special Care patients (Table III). However, as many as 62.8% (155) overall felt this same level of confidence, despite saying ‘No’ to receiving sufficient clinical exposure.

Special Care course adequacy in individual dental schools

When considering the responses to the questions ‘Do you feel you received adequate teaching on Special Care Dentistry?’ and ‘Do you feel you gained enough clinical experience treating Special Care patients?’, in the majority of cases, individual students strongly indicated that they felt teaching was insufficient. However, two of the ten responding dental schools produced data that contradicted this, demonstrating that undergraduates were happy with the amount of teaching in this subject. Interestingly, school C provided 49 hours of lectures but only 35.4%
**Figure 1**

*Student reported confidence levels when treating different Special Care groups*

![Confidence Levels Chart](Image)

**Figure 2**

*Student self-rating of their communication skills when interacting with different Special Care groups*

![Communication Skills Chart](Image)
of students felt this was sufficient. Many undergraduates considered that clinical experience was lacking and at dental schools B, D, K and L students were unanimous in this opinion.

**Discussion**

This study was limited by the poor return of questionnaires, the staff version from only nine of the fifteen dental schools and student questionnaires from ten dental schools. Nonetheless, both types of questionnaire provided a reasonable sample of data from the British and Irish dental schools. Therefore, the conclusions may apply to other dental schools in the UK and Ireland. Unreturned questionnaires may have been mislaid, staff members might have had insufficient time to complete one, or course timing may have contributed to the poor response rate. A future survey could be carried out over a more extended period that would allow individual courses to be included, thereby encouraging and facilitating greater questionnaire return.

According to the GDC, undergraduates should ‘Gain an awareness of treating medically compromised and physically compromised patients’ and be able to ‘Provide appropriate care for vulnerable people’ (General Dental Council, 2002). The restricted amount of hands-on experience, and sometimes, low levels of clinical confidence amongst final year students, would indicate that the above learning outcomes are not being met by most dental schools of the United Kingdom and Ireland. Indeed, a majority of staff respondents agreed that this is the case. Some responding dental schools stated that they formally assessed student knowledge and clinical competence in SCD. It would be interesting to discover the criteria involved in these assessments when the same staff members felt that students were meeting neither the GDC nor QAA requirements.

The Quality Assurance Agency for Higher Education states that undergraduate dental students should ‘Recognise their duty of care to manage the oral health of the patient with special needs’ and be able to manage ‘The dental health care needs of those who may be considered to be socially excluded’ (Quality Assurance Agency, 2002). The information collected during the study implies that despite some students feeling they had received adequate theoretical teaching, this did not seem to prepare them sufficiently for clinical treatment of this group of patients. It appears that, although through Special Care didactic teaching, students have an awareness of their responsibilities towards these patients, patient management skills could be much improved by providing every student with the opportunity for practical experience. This is not surprising since all dental training requires hands-on experience, as well as theoretical knowledge, to allow undergraduates to become competent at procedures and to increase their clinical confidence.

It appeared that if an undergraduate thought they received enough clinical experience they were subsequently more likely to feel prepared for treating such patients, this being irrespective of whether they had gained as much experience as some of their peers. Similarly, it can be argued that there is a correlation between a student’s confidence in their clinical ability and their opinion of teaching and hands-on experience. If a student has a negative attitude about their clinical skill with Special Care patients, it appears they were more likely to state that the teaching or amount of hands-on experience gained was not acceptable.

Definitive conclusions could not be drawn regarding overall student confidence levels when treating Special Care patients because of non-response bias, possibly influenced by the questionnaire design. For example, the middle category for response options (“Quite confident”) is recognised as an attractive answer for respondents since it allows them to avoid the two alternative extremes; this phenomenon is recognised as the error of central tendency (Oppenheim, 1992). However, the findings support the observations of Matthews et al. (1993), that at qualification level, Special Care patients ‘Would not be managed confidently’. The combination of negative student opinion of the Special Care course and their less than confident attitude towards their own clinical skills raises doubt about whether these students would fulfil their duty of care once they graduated. As Matthews et al. (1993) assert, ‘Willingness to undertake a procedure is directly related to confidence’.

Nunn (2000) states that among the reasons given by dental practitioners for failing to provide acceptable dental services for Special Care patients, a ‘Lack of training and experience’ contributes to their reluctance. It is apparent that a number of dental schools are able to provide more hands-on experience for undergraduates than others, with one school stating that they provided 54 hours across years three, four and five. Improving the situation in some dental schools may be challenging. The ‘Barriers to implementing change’ described by Thompson et al. in 2001, include reference to the possibility that, in some dental schools, SCD teaching has ‘A low status’. There is also mention of a ‘Lack of resources and evidence to suggest that planned change would result in improvements’ (Thompson et al., 2001). Comments provided by some staff members suggest it is as a direct consequence of the restrictions of an overly full curriculum that the provision of more didactic and practical teaching is made difficult. For example, School C commented that ‘the introduction of a new subject into the curriculum has to be at the expense of existing subjects or clinical experience’. Dental school N agreed and stated that they have introduced ‘E-learning’ in an attempt to overcome ‘curriculum limitation’.
### Table 2
Adequacy of teaching and student confidence treating Special Care patients

<table>
<thead>
<tr>
<th>Adequate teaching?</th>
<th>Count</th>
<th>Not at all</th>
<th>Quite</th>
<th>confident</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
<td>20</td>
<td>75</td>
<td>9</td>
<td>104</td>
</tr>
<tr>
<td>% within adequate teaching?</td>
<td></td>
<td>19.2%</td>
<td>72.1%</td>
<td>8.7%</td>
<td>100.0%</td>
</tr>
<tr>
<td>% within how confident treating overall?</td>
<td></td>
<td>23.0%</td>
<td>41.9%</td>
<td>56.3%</td>
<td>36.9%</td>
</tr>
<tr>
<td>Nb</td>
<td></td>
<td>67</td>
<td>104</td>
<td>7</td>
<td>178</td>
</tr>
<tr>
<td>% within adequate teaching?</td>
<td></td>
<td>37.6%</td>
<td>58.4%</td>
<td>3.9%</td>
<td>100.0%</td>
</tr>
<tr>
<td>% within how confident treating overall?</td>
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<td>77.0%</td>
<td>58.1%</td>
<td>43.8%</td>
<td>63.1%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>87</td>
<td>179</td>
<td>16</td>
<td>282</td>
</tr>
<tr>
<td>% within adequate teaching?</td>
<td></td>
<td>30.9%</td>
<td>63.5%</td>
<td>5.7%</td>
<td>100.0%</td>
</tr>
<tr>
<td>% within how confident treating overall?</td>
<td></td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
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</table>

### Table 3
Clinical experience and student confidence treating Special Care patients

<table>
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<tr>
<th>Enough clinical?</th>
<th>Count</th>
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<th>Quite</th>
<th>confident</th>
<th>Total</th>
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<tr>
<td>Yes</td>
<td></td>
<td>3</td>
<td>24</td>
<td>8</td>
<td>35</td>
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<td>% within enough clinical experience?</td>
<td></td>
<td>8.6%</td>
<td>68.6%</td>
<td>22.9%</td>
<td>100.0%</td>
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<tr>
<td>% within how confident treating overall?</td>
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<tr>
<td>% within enough clinical experience?</td>
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<td>34.0%</td>
<td>62.8%</td>
<td>3.2%</td>
<td>100.0%</td>
</tr>
<tr>
<td>% within how confident treating overall?</td>
<td></td>
<td>96.6%</td>
<td>86.6%</td>
<td>50.0%</td>
<td>87.6%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
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<td>179</td>
<td>16</td>
<td>282</td>
</tr>
<tr>
<td>% within enough clinical experience?</td>
<td></td>
<td>30.9%</td>
<td>63.5%</td>
<td>5.7%</td>
<td>100.0%</td>
</tr>
<tr>
<td>% within how confident treating overall?</td>
<td></td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>
Gerodontology is included in SCD education in the majority of dental schools. However, due to the lack of detailed questioning about the delivery of this subject, it is not possible to interpret whether this teaching was satisfactory. Even so, the higher numbers of undergraduates who felt ‘Confident’ when treating frail, older patients would suggest that students are provided with sufficient clinical experience for treating such patients. In 2005, 16% of the population was over 65 years of age old and the number of people over 85 years rose to 1.2 million (National Statistics, 2006).

The number of undergraduates who indicated a desire to pursue SCD at post-graduate level was 27.3%. This could reflect a less than enthusiastic attitude towards care of this group of patients, as in some cases, students may wish to avoid the unknown. This is particularly relevant to those students who did not gain any clinical experience with these patients. If undergraduate exposure to SC patients could be increased, this may contribute towards encouraging undergraduates to continue SC training. This in turn would have a positive influence on the standard of care for these patients in general practice.

Finally, investigations into the quality and quantity of SCD teaching could be developed in a number of ways, for example, including the question ‘Are you male or female?’ would provide an interesting insight into whether there is a gender-related difference in the popularity of this subject. Individuals’ judgement of clinical confidence levels and estimation of the quantity of hands-on experience gained, may also vary between the genders. Smith et al. (2006) compared the ‘Self-reported estimates of clinical experience’ between the genders in terms of the amount of clinical restorative work they had undertaken. The study by Smith et al. (2006) concluded that ‘Male students over-report their clinical experience while females slightly under-report it’.

Furthermore, in 2000, Leitch and Girdler found variation between staff and student responses when estimating numbers of patients seen. Questionnaires for future surveys could give students the opportunity to state how many hours of various types of teaching they received. This may reveal if the staff members co-ordinating SCD teaching could be developed in a number of ways, for example, including the question ‘Are you male or female?’ would provide an interesting insight into whether there is a gender-related difference in the popularity of this subject. Individuals’ judgement of clinical confidence levels and estimation of the quantity of hands-on experience gained, may also vary between the genders. Smith et al. (2006) compared the ‘Self-reported estimates of clinical experience’ between the genders in terms of the amount of clinical restorative work they had undertaken. The study by Smith et al. (2006) concluded that ‘Male students over-report their clinical experience while females slightly under-report it’.

Conclusions

There is substantive evidence that a detailed revision of current SCD teaching should be made in each dental school, with emphasis on including much greater opportunity for clinical experience for undergraduates. It is understood that curriculum restraints may lead to difficulties with this, yet, in a society where patients in vulnerable groups are rightly demanding equal access to high quality dental care, it is vital that dental undergraduates are suitably equipped. All dental professionals should have an understanding of disability and how it impacts on oral health, as well as the effect upon an individual. This study verifies the statement by Nunn and Murray (1988) that improvement in the quality and quantity of undergraduate training in the management of SCD patients is the only manner in which negative attitudes amongst graduate dental surgeons may be avoided.

Acknowledgements

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References


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