

IN BRIEF

- There is a need for discussion on the teaching of complete denture construction to undergraduates as a result of the inception of specialist lists, the impending introduction of clinical dental technicians and the publication of the GDC draft document on the undergraduate curriculum.
- Since the sixties curriculum teaching time for complete dentures have been reduced to the minimum and the GDC draft document seems to allow for further reduction.
- A guide to clinical standards have been published by BSSPD and should form the objective of undergraduate teaching.
- There is a need for a wider discussion nationally to ensure that new graduates continue to be able to offer a complete denture service to the public.

The future of teaching of complete denture construction to undergraduates

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For some time there has been a need to discuss the undergraduate complete denture curriculum in the light of the inception of the specialist lists and the impending introduction of clinical dental technicians to ensure that general dental practitioners can continue to provide a complete denture service to the public. Publication in draft form by the General Dental Council of their document *'The First Five Years – The undergraduate dental curriculum'*¹ increases the need for this debate.

Since the sixties there has been a gradual reduction in curriculum time devoted to the teaching of both the clinical and technological aspects of complete denture construction. In some respects these changes have reflected changes in treatment needs, in other respects they have followed trends that have often been rather optimistically reported or accepted on the basis that the loudest voice must be right.

The loss of curriculum time has been difficult for teachers of complete denture prosthetics to handle. It has almost always resulted in attempts to squeeze a quart into a pint pot with the loss of a bit of froth, rather than try to rationalise, on the basis of aims and objectives, what is required. This is particularly true in regard to the balance between clinical and technical teaching. The result has often been insufficient time to teach adequately.

The recent introduction of the Specialist Lists allows an opportunity to discuss the

content of the undergraduate curriculum in relation not only to the GDC recommendations for undergraduate training but also the curricula for specialist training in restorative dentistry and more importantly in prosthodontics. Perhaps the most sensible way of approaching this problem is from the perspective of the patient base. Most practitioners who treat edentulous patients can divide these patients into two main groups: those who can manage dentures and those who have difficulty. The undergraduate curriculum should aim to equip graduates to treat the first group properly and attempt to recognise the second group and refer them for specialist care. The specialist should then be trained to deliver that care.

The difficult question is: What do undergraduates need to study to be able to reach this level of competence? And, how should it be taught? Traditional courses have included many hours of technology teaching and practice, and this has usually been the area to suffer most when time restraints were imposed. Now clinical teaching time is significantly reduced and in many schools technology teaching has all but disappeared. The General Dental Council¹ appears to have left it open to dental schools to reduce still further the amount of teaching of complete dentures to a point where competence will not be achieved by the time of graduation. Only a

well thought out strategy for complete denture teaching will preserve its place in the curriculum.

STANDARDS FOR REMOVABLE PROSTHODONTICS

Standards for complete denture construction have been published by The British Society for the Study of Prosthetic Dentistry² and remain unchallenged as the benchmark for clinical acceptability in this country. In the absence of any other standard, it would seem indisputable that as a minimum, students should have sufficient clinical experience of the stages outlined in the BSSPD guidelines to enable them to achieve a level of expertise commensurate with treating the type of patient who can manage dentures.

Students must be cognisant of all the technical stages to allow them to prescribe sensibly and accurately. Whilst this is best achieved by doing, it may also be achieved by the use of visual aids. However some skills such as pouring casts, making custom trays and wax rims may be useful to learn. It is critically important that students learn to distinguish between work which is up to standard and fulfils the requirements of their prescription and that which does not. This can be learnt from looking at and criticising examples. The students do not necessarily need to make the mistakes themselves, but they do need to know what must

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be done to correct them. The time needed to reach this level of understanding should not be underestimated.

Before I took the Chair in Prosthetic Dentistry in Hong Kong at the beginning of 1980, I had spent my career at Guy's and The Royal Dental Hospital. These were the two schools that devoted the greatest amount of curriculum time to prosthetic dentistry and denture technology. The students were required to follow an extensive technique course and do all the technical work for their patients. There is no doubt that the students were well trained in the subject, but opinions varied as to the need for such an extensive training and pressure to expand other subjects and introduce new ones has generally resulted in a restriction of the technical component of the course. When I went to Hong Kong in 1980, the

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University, on the advice of its Dental Academic Advisory Committee, had already decided that the time available for technology teaching would be much less than similar courses in UK dental schools, but this was to be counter-balanced by provision of technical support for the students.

The prosthetic dentistry course that was adopted was different to traditional courses in some other respects as well. We were told that we would find it hard to attract enough complete denture patients for student teaching. This, together with a conviction that a more logical course can be constructed if the complete denture component comes last, led us to teach complete dentures in the fourth year. It tran-

spired that there were plenty of complete denture cases and we soon had a waiting list over 2 years long, but the patients were not seduced away from the registered dentists. They had previously been treated by the unregistered dentists and unlicensed denturists.

The basic course consisted of teaching of both the clinical and technical aspects. The overriding principle was that the clinical work preceded the technical work at each stage and this put the technical exercises into context and improved understanding. A clinical demonstration was followed by the student's clinical session. Then a technical demonstration was followed by a technical exercise based on the demonstration. The technical work for all the students' patients was done by a technician as is now recommended by the GDC.¹ In this way the students became familiar with the techniques involved in making dentures, without becoming expert and time was saved in that the patients' technical work was done by technicians. Students completed this course with a good understanding of the technology. External examiners' reports were favourable and GDC recognition was achieved. Several factors contributed greatly to this. The production technicians were in house, were well trained and well qualified – all had the advanced City and Guilds Certificate and as they inevitably developed quite close relationships with their students, they did a lot of on the job teaching. Unfortunately, the current trend, in the UK, of sending technical work to outside laboratories, which have been appointed on the basis of competitive tender, precludes this type of learning experience.

In the UK we have already reached the stage where the removable prosthodontics curriculum has been pared to the bone and no further cuts are possible without a reduction in standard that would leave new graduates inadequately trained. The GDC document *'The First Five Years'*¹ seems to allow for further cuts and suggests that this will be the case and speaks of the need for further training without spelling out what it has in mind. However, the problem is wider than just the training issue. Will the graduates, who will not have been taught to a level of competence, be advised by the GDC

that they are not licensed to make dentures (or oversee clinical dental technicians) until they have taken further approved training or, will it be left to their medico-legal societies to give them this advice? In either case, they will be put in an invidious position. Before such a major change takes place, the situation must be spelt out to the profession and the public.

THE FUTURE – THE NEED FOR A NATIONAL DEBATE

Current evidence suggests that there will always be a need for complete dentures to be made in UK. This need will gradually decrease. It is forecast that, in general, cases will become more difficult³ and eventually they will nearly all be treated by specialists. Only when this forecast becomes reality, will competence at making complete dentures not be required of new graduates. Much thought will then have to be given to designing a course, which gives an overview of the subject and creates enough interest to stimulate some to progress to postgraduate study.

However, the time when the complete denture service will be provided almost entirely by specialists is still a long way off. In the meantime, undergraduate teaching has already been reduced to the point where many new graduates are not confident (some might even say not competent) to treat edentulous patients. For the foreseeable future, time must be found and a curriculum designed to produce graduates capable of treating those patients who are able to manage dentures. The will to do this seems to be missing and for this reason there is a need for a national debate on curriculum content, coupled to the needs of patients and this debate needs to extend beyond the GDC and the curriculum committees of the dental schools.

- 1 *The first five years The undergraduate curriculum.* General Dental Council Consultation document, 2001.
- 2 The British Society for the Study of Prosthetic Dentistry. *Guidelines in Prosthetic Dentistry and Implant Dentistry.* London: Quintessence, 1996.
- 3 Steele J G, Treasure E M, Pitts N B, Morris J, Bradnock G. Total tooth loss in United Kingdom in 1998 and implications for the future. *Br Dent J* 2000; **189**: 598-603.

The views outlined above are personal and must not be construed as being the views of any of the institutions mentioned above.