An investigation into the numbers of dentists from 19 European Economic Area (EEA) member states currently registered to work in the United Kingdom and key differences between the practise of dentistry in the UK and their member states of origin

R. Patel,[1] K. A. Eaton,[2] A. Garcia,[3] V. Rincon[4] and J. Brooks[5]

IN BRIEF

- Highlights the increasing numbers of non-UK qualified EEA dentists practising in the United Kingdom.
- Summarises the key differences in the practise of dentistry in 19 EEA member states.
- Briefly discusses the need for induction training for non-UK qualified EEA dentists before they enter practise in the UK.

GENERAL

The aim of this short communication is to highlight the numbers of non-UK EEA qualified dentists currently registered with the General Dental Council (GDC) and to present a brief overview of the systems for the provision of oral healthcare in the non-UK EEA member states identifying differences in practise. The relevant data were gathered for the National Clinical Assessment Service (NCAS) as part of a wider project. It was found that at 31 December 2010, 28% of dentists registered with the GDC had not qualified in the UK. Of these more than 6,300 were European Economic Area (EEA) dentists with non-UK qualifications. The nature of their practise varied widely from member state to member state. The implications of these findings are discussed briefly.

INTRODUCTION

This short communication reports and discusses the data collected in two areas: the numbers of dentists from 19 EEA states, who have been registered to practise in the United Kingdom (UK) over the last ten years, and key differences in the practise of oral healthcare in the 19 EEA states.

The number of dentists originating from other EEA member states and from overseas, registered in the UK, has increased significantly in the last ten years (Fig. 1). In 2000, the percentage of these dentists was 17%; by 31 December 2010 it had risen to 28.0% (Fig. 1).

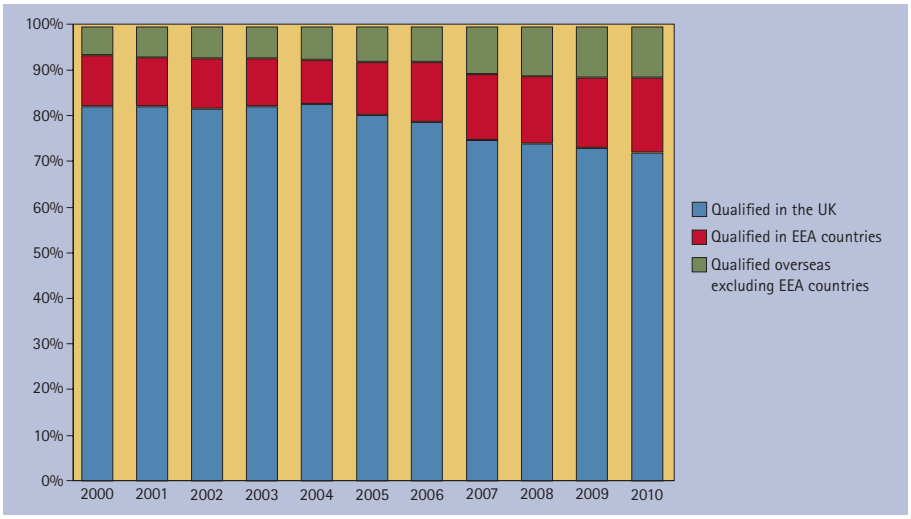

Fig. 1 Percentage of GDC registered dentists by place of qualification 2000–2010

[1]*Dental Officer, Bromley PCT; [2]Visiting Professor, UCL Eastman and KCL Dental Institutes, Honorary Professor University of Kent, Advisor to the Council of European Chief Dental Officers; [3]Freelance Dental Public Health Analyst; [4]General Dental Practitioner; [5]Associate Director (Dentistry) National Clinical Assessment Service
*Correspondence to: Reena Patel, Mottingham Special Care Dental Clinic, Kimmeridge Road, Mottingham, London, SE9 4EB
Email: ernee_tap@hotmail.com

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By 31 December 2010, of the 38,377 dentists who were registered with the General Dental Council (GDC), 10,768 had qualified outside the United Kingdom (UK).[1] Of these 6,338 were nationals of member states of the European Economic Area (EEA - the 27 EU member states plus Iceland, Liechtenstein, Norway and Switzerland) who had obtained their primary dental qualification from an EEA dental school.[1]

There are over 170 dental schools in the EEA and in spite of efforts to harmonise undergraduate dental education throughout this area by the DentEd project[2] and the elaboration of Competencies of a European Dentist by the Association for Dental Education in Europe (ADEE).[3] A number of studies have demonstrated the variability of the undergraduate dental curriculum in the different dental schools of the EEA and in the

Table 1 List of the topic areas investigated

Regulatory mechanisms	Education and training	Support systems	Dental team and skill mix	Dental delivery	Quality assurance mechanisms	Culture
Regulation and registration The ethical code Indemnity insurance Corporate dentistry Health and safety Ionising radiation Hazardous waste	Undergraduate education Vocational training and foundation training Specialist training	Dental associations	Roles of dental care professionals	Oral health systems and finance	Fitness to practise Disciplinary matters Continuing dental education Revalidation	Ethnicity and culture Cultural differences Views towards preventative dentistry

level of clinical experience achieved during dental undergraduate education.[4-7] Such variations occur within member states, as well as between member states, and indeed between dentists graduating from the same dental schools at the same time. A further complication is that a small minority of UK citizens are now qualifying as dentists from EEA dental schools, other than those in the UK.

The Directive on the recognition of Professional Qualifications for Dentists (PQD) 2005/36 EC gives EEA nationals who graduated from EEA dental schools the right to establish practice anywhere in the EEA, without the need to undertake further education or training.[8] Thus although all UK graduates who are UK nationals are required to undertake a year's vocational training (now referred to as year one of foundation training) before they can practise independently in the General Dental Services (GDS) of the NHS and non-EEA nationals have to show equivalent experience, this requirement is not placed upon EEA graduates once they have registered with the GDC. There is a perception, supported by an increasing number of non-UK EEA graduates being referred to NCAS[9] and to the GDC, that this has led to a number of EEA dentists not fully understanding the implications of working in dental practise in the UK. This may subsequently result in a variety of difficulties which have a number of potential causes,[9] including lack of clinical knowledge and experience, lack of understanding of the culture of healthcare in general and dental care, in particular, in the UK, inappropriate attitudes and inadequate induction training on arrival in the UK.

AIMS

Against this background, the aims of this part of the review were to:

1. Explore the numbers of non-UK EEA qualified dentists by member state and year of first GDC registration
2. To review systems for the provision of oral healthcare in the non-UK EEA member states with the highest numbers of GDC registrants and identify differences in practise.

METHODS

For the first part of the study, to address the first aim the GDC were approached with a request for data on non-UK EEA qualified dentists who had registered in 2007, 2008 and 2009. Subsequently, during the production of this short communication, the GDC was asked for and provided data for 2010. The data for 2010 are included in the introduction and discussion sections but not in the results section, as they were not available at the time of the NCAS survey.

For the second part of the study, all available literature was reviewed, including unpublished grey literature. Representatives of national dental associations, European Chief Dental Officers and other stakeholders were interviewed or consulted to verify the accuracy and currency of the information that had been gathered. Search terms included: dentistry in Europe, number of dentists registered in the UK, and the European country name followed by the following terms - dental professionals, dental workforce, dental schools, dental education, dentists, dental team, dental regulation system, dental registration, dental complaints, quality assurance, number of dentists, vocational training, dental delivery, dental service.

The review of the literature investigated regulatory mechanisms, education and training, support systems, dental team and skill mix, the delivery of oral healthcare, quality assurance mechanisms and cultural factors. Within each field, the topics were sub-divided as shown in Table 1.

The resulting information was used to produce the internal resource for NCAS.

RESULTS

Numbers of non-UK qualified dentists registered with the GDC

On 31 December 2009, 5,628 (97%) of non-UK EEA qualified dentists, who were registered with the GDC, had graduated in one of the 19 member states shown in Table 2.

In Table 2, in terms of the change in numbers of registrants between 2007 and 2009, 'stable' indicates very little change in numbers of registrants from those member states. In most cases, this is a difference of less than five registrants between these years. However, Sweden is the exception with a reduction of 16 registrants between 2007 and 2009.

A total of 112 registrants who had graduated from dental schools in a further eight EEA member states accounted for only 3% of all non-UK EEA registrants (Table 3). It should be noted that there are no dental schools in Cyprus, Liechtenstein or Luxembourg.

The countries listed in Table 3 were therefore excluded from the study. The review concentrated on the 19 member states from which more than 50 dentists were registered with the GDC in December 2009, plus Malta, nearly 20% per cent of whose dentists are registered with the GDC (Table 2).

Background factors

There was relatively little relevant literature on this topic, however, two publications were found to be of particular use. They were: the Council of European Dentists' *Manual of Dental Practice, Version 4* (2008)[10] and *Oral Healthcare Systems in the Extended European Union* (2004),

Table 2 Non-UK EEA qualified dentists by country and year of first GDC registration

Country	No. on GDC Register: 2007	No. on GDC Register: 2008	No. on GDC Register: 2009	Trend
Belgium	53	51	51	Stable
Bulgaria	45	116	167	Increasing (3.7×)
Czech Republic	48	62	84	Increasing
Denmark	131	128	127	Stable
Finland	40	34	36	Stable
France	82	82	78	Stable
Germany	474	477	475	Stable
Greece	419	449	466	Increasing (1.1×)
Hungary	146	187	202	Increasing (1.4×)
Ireland	661	652	625	Decreasing
Italy	117	148	158	Increasing (1.4×)
Lithuania	105	102	127	Increasing
Malta	31	37	33	Stable
Netherlands	49	52	50	Stable
Poland	848	872	849	Stable
Portugal	216	272	338	Increasing (1.6×)
Romania	155	255	344	Increasing (2.2×)
Slovakia	39	46	46	Stable
Spain	281	288	390	Increasing (1.4×)
Sweden	996	988	980	Stable

Table 3 EEA member states with relatively low numbers of GDC registrants

Country	No. on GDC Register: 2007	No. on GDC Register: 2008	No. on GDC Register: 2009	Trend
Austria	3	5	4	Stable
Estonia	17	16	16	Stable
Finland	40	34	36	Stable
Iceland	3	2	4	Stable
Latvia	22	28	38	Increasing
Norway	37	36	40	Stable
Slovenia	0	1	0	Stable
Switzerland	12	15	10	Stable

which was produced for the Council of European Chief Dental Officers (CECDO).[11]

From the analysis of the available literature, a number of key points were apparent. They are listed in the first (left-hand) column of Table 4 which summarises the key points to consider when inducting/supporting a qualified dentist from a non-UK EEA member state, or indeed any dentist to work in the UK.

DISCUSSION

These results have demonstrated the numbers of non-UK EEA qualified dentists by member state and year of first GDC registration. The study has also achieved its aim of reviewing systems for the provision of oral healthcare in the non-UK EEA member states to identify differences in practice. However, certain limitations are evident. Firstly, the analysis relies heavily on the *Council of European Dentists, Manual of Dental Practice Version 4*.[10] In particular topic areas, data and information may not have been fully up-to-date or representative of the current situation. Discussion and feedback from relevant European stakeholders was therefore particularly helpful, but this was not possible for all countries and in all topic areas. One topic area which has not been included is clinical training, including radiography, oral surgery, etc. It should also be borne in mind that in presenting the results of this study, it was challenging to reduce complex situations to simple tables, which as a result, may demonstrate the general trend but not minor variations. Hence a large number of explanatory footnotes were utilised to explain these variations. In this short communication only the broad picture can be presented.

It is clear that over the last ten years there has been a very considerable increase in the numbers of non-UK dentists registering with the GDC. The rise in number from EEA states is particularly noticeable. The question arises as to why these dentists have registered to practise in the UK. It has been suggested that the migration of dentists may be due to economic, political and cultural factors.[12] In the 1990s there were dramatic increases in the numbers of dentists from South Africa and Sweden who registered with the GDC. At 31 December 2009, 1,383 South African and 980 Swedish dentists were registered with the GDC.[1] However, their numbers have been stable for some years. The rise in the numbers of South African dentists registered with the GDC coincided with political and economic change in South Africa. The rise in the number of Swedish dentists coincided with changes in the payment system for dental care.

In the middle of the last decade, the Department of Health actively encouraged the recruitment of dentists from Europe, as it was perceived that there was a shortage in the UK. Nearly 1,000 dentists were recruited from Poland. It appears that the majority migrated on economic grounds. The data from the GDC indicate that their numbers were stable between 2007 and 2009. These data also indicate that over these three years, the greatest increases in registrants from EEA states were seen in those from Eastern European states and, in particular Romania, and Spain and

Table 4 Summary table of key differences in dental practice in the 19 EEA states

Key differences	Belgium	Bulgaria	Czech Republic	Denmark	France	Germany	Greece	Hungary	Ireland	Italy	Lithuania	Malta	Netherlands	Poland	Portugal	Romania	Slovakia	Spain	Sweden
Is professional dental indemnity compulsory?	Y	Y	Y	Y	Y	N	N	Y	N	N	Y	N	N	Y	N	Y	Y	Y	Y
Is hepatitis B inoculation compulsory?	Y	N	Y	N	Y	N	N	Y	N	N	N	Y	Y	N	N	Y	Y	N	N
Is continuing professional education compulsory?	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	N	N	Y	N	Y	Y	N	N
Experience of working in a publicly funded health service	L	L[2]	L	H	L	L	L	L	M	L	M	L	M	L[6]	L	L[8]	M	L	M
Experience of clinical governance requirements	L	L	L	L	L	M	L	L	L	L	L	L	M	L	L	L	L	L	M
Is a vocational training programme available?	Y[1]	N	Y[3]	Y[4]	N	Y	N	Y[5]	Y	N	Y	Y[13]	N	Y[7]	N	N[9]	N[10]	N	N[11]
Is a foundation training programme available?	N	N	N	N	N	N[12]	N	N	N	N	N	N	N	N	N	N[9]	N[10]	N	N
Experience of working with a dental nurse	L	L	H	H	L	H	L	H	H	H	H	M	H	H	H	L	H	H	H
Experience of working with a dental hygienist	N	N	L	H	N	L	N	L	H	M	L	M	H	L	L	L	L	H	H
Experience of working with a clinical dental technician	N	N	N	H	N	N	N	N	L	N	N	N	H	N	N	N	N	N	N
Experience of working with a dental therapist	N	N	N	N	N	N	N	N	N	N	N	N	H	N	N	N	N	N	N

Colour key to Table 4

L	Low/limited	M	Moderate	H	High
N	No			Y	Yes

1. If qualified after 2002
2. If qualified after 1990, before then high
3. If qualified before 2009
4. Only if the practitioner has graduated in the last 10 years
5. If qualified before 2004
6. If qualified after 1992, before then high
7. If qualified since 1993
8. Unless qualified before 1990
9. If qualified between 2001 and 2009. Some new graduates are now offered VT
10. If qualified after 2009
11. Unless qualified before 1993
12. In Germany there is a two year period in which new graduates work as an assistant to an established dentist. There is no training in secondary care and the training does not equate to foundation training
13. VT is available in Malta but is not compulsory

Portugal. These three states have opened a number of private dental schools in the last 15 years. However, in all three there is very little publicly funded oral healthcare and less than 40% of the population sought oral healthcare.[13,14]

Hence there is significant under and un-employment of dentists in these three countries and an economic incentive for migration.

There appeared to be considerable variations in the key factors listed in summary Table 4. As far as the first three – compulsory professional indemnity and inoculation against hepatitis B and continuing professional education – were concerned, although not compulsory in some EEA states, they are strongly encouraged in all 19 states. Interestingly the reason that inoculation against hepatitis B is not compulsory in Germany relates to German law which for historical reasons forbids any compulsion for any medical procedure.

Oral healthcare is not funded directly by the state in the majority of the 19 EEA states and few dentists work for a 'public body' as salaried employees. However, in a number of the states, where dentists have little experience of working in a publicly funded health service, they indirectly work for the state as private contractors to a nationally or locally organised compulsory insurance scheme coordinated by non-governmental sick funds such as the Krankenkassen in Germany. Furthermore, in many former 'Eastern Bloc' states, in the last 20 years, there has been a change from a purely public dental service to a purely private system.

The investigation confirmed that, with few exceptions, the concepts of clinical audit and clinical governance are little known in the majority of the 19 EEA states

reported in this paper, as was the concept of foundation training. Nevertheless, the need for supervised clinical training immediately after graduation was appreciated in many of the 19 states, nine of whom offer vocational training. The high number of footnotes for this topic in Table 4 indicate the changes that have occurred with regard to vocational training and before joining the European Union, up to three years' supervised clinical training, immediately after graduation was required in 'Eastern Bloc' EEA states.[10]

Perhaps the most obvious differences focused on the use of the dental team, particularly the wider dental team. In certain countries, for example, in the Netherlands, the team approach is very well developed with all dentists working with full-time chairside nursing support and large numbers of dental therapists, hygienists and some clinical dental technicians.[10,11] However, just across the border, in Belgium, few dentists work with chairside assistants (dental nurses) and there are no dental hygienists or therapists or clinical dental technicians.[10,11]

Care should be exercised when interpreting the information described in this study. Because one dentist from a member state has behaved in a particular way, it would be grossly unfair to assume that all dentists from the member state in question would behave in a similar manner. Poor communication is frequently the cause for patient complaints.[9] Recently Dental Protection Limited has suggested that 70% of litigation arising from oral healthcare is related to poor communication.[15] Language can also play a key role and although an EEA dentist may speak adequate English under normal conversational circumstances, he or she may have considerable difficulty understanding a regional accent or in explaining dental terms in language that a patient can understand. Such issues are not dealt with directly in this resource and can equally apply to some UK graduates.

Currently, unlike UK graduates or those from non-EEA states, EEA nationals with non-UK qualifications are not required to undertake foundation (previously vocational) training or to show equivalent experience before they can practise independently. Anecdotally, it has been claimed that this frequently causes problems when they enter practise in the UK. In view of the differences in dental practise between the EEA member states this is unsurprising. In many parts of the UK, induction training is provided to try to prevent problems from arising.

However, at present, it appears that EU law prevents such training becoming a compulsory requirement. Research is needed to establish the extent to which dentists from the EEA with non-UK qualifications are the subject of patient and other complaints, in comparison with UK and non-EEA dentists and into the effectiveness of the induction training that is currently being provided in preventing such problems.

It is intended that this study will provide a foundation for future research and the development educational resources. In particular, the further development of training and induction programmes for non-UK EEA qualified dentists aligned with an appropriate competency framework could be especially useful.

CONCLUSIONS

- It is clear that there has been a substantial rise in the number of dentists with non-UK qualifications who have registered with the GDC in the last ten years
- Non-UK qualified dentists from the EEC account for 60% of 10,000 plus non-UK qualified dentists
- There are wide variations between EEC member states in manner in which dentistry is practised
- There is a need for the further development of training and induction programmes for non-UK qualified dentists.

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Author Kenneth Eaton is a freelance dental academic and Adviser to the Council of European Chief Dental Officers.

Kenneth Eaton planned and supervised the academic aspects of the work and edited the drafts; Reena Patel drafted the paper; Angela Garcia performed the literature review; Victoria Rincon performed the literature review; Janine Brooks supervised the work and edited the drafts.

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