LETTERS TO THE EDITOR

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NEED, DEMAND AND TIME

Sir, I read the thoughtful, well referenced article on manpower planning in periodontology (*BDJ* 2014; **217:** 399-402) as someone with an interest in workforce planning in practice from Dentists with a Special Interest and at specialist level. The authors put the case very clearly based on the incidence of periodontal disease, this being the need for care, as to the number of specialists who might be required if all the disease is to be treated. From a workforce perspective this is only part of the equation as a needs-based model looks at maximum provision if all the need is to be met. Another part of the workforce equation to be considered is: which clinicians can deliver what aspects of the care required?

In addition there is the consideration of demand. How many patients want advanced periodontal therapy? How many will comply with regimes? My clinical experience over 30 years in general practice indicates that only a few of those with moderately severe periodontal disease wish to have the full gambit of therapies; most prefer to opt for a simpler therapy and accept the long-term outcome rather than go through regular treatments. The authors suggest that 14.3% might need specialist care. From a workforce perspective if demand for advanced therapy from a specialist is less than one third then the workforce plan would be very different. This is before one considers who can deliver the care.

Paul Batchelor (*BDJ* 2014; **217:** 405–409) in the same edition notes that there is little evidence to support the use of routine scaling and polishing. I think all authors agree that regular review of oral hygiene (OH) and re-enforcement is of value to all patients. If a preventive approach is adopted and referral to intermediate and specialist is based on compliance with OH regimes then the workforce need may be considerably less. Sadly, the biggest challenge is gaining patient compliance with regular OH regimes and this perhaps requires the dental team to develop communication and motivational skills, and having the time to talk and more especially listen to patients.

A. G. Miller, Taunton

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DENTIST LEADERSHIP

CDO: Vital Professional Adviser

Sir, Professor Wilson questioned whether the role of the Chief Dental Officer (CDO) (*New Chief Dental Officer – a changed role*, *BDJ* 2014; **218:** 1) had been weakened by the changes following the introduction of the Health and Social Care Act 2012. This response argues that the CDO role remains a vitally important and influential one.

Following the Act, the Department agreed that it would be sensible for NHS England to host the Chief Professional Officers and other leading clinical positions, including the CDO role. This recognised the central role that NHS England was to play in improving health outcomes for people in England, with less direct control from Ministers. This is an aim that I suspect many dentists would support.

Professor Wilson questioned whether as a result of these changes 'the profession ... may be left worse off in terms of high level advice to Ministers and the government'. This has not been the case. The CDO has continued to advise Ministers on topics ranging from dental contract reform to professional regulation. It is clear that Ministers very much value the CDO role and the perspective it can bring. The esteem in which the CDO's advice is held has not been diminished.

Furthermore, the CDO continues to make a contribution well beyond NHS England and the Department of Health. Since April 2013 the CDO has offered advice across Government including to the Department for the Environment and Rural Affairs on reducing the use of dental amalgam in order to comply with EU policy on minimising the impact of mercury on the environment. There has also been significant engagement with the Department for Business, Innovation and Skills around the numbers of dental students in training and the issue of products that are appropriate to use for both children and adults in tooth whitening.

This reality is confirmed by the job description for the new CDO which makes clear that the post holder will 'provide leadership and advice to the Department of Health (DH) to enable it to discharge its functions with regard to the dental profession, and to advise other government departments' and it explicitly names Ministers as recipients of advice.

The real substantive change to the CDO role following the reforms is not actually picked up by Professor Wilson. That is the enhanced part played by Public Health England in terms of preventing dental disease and championing initiatives such as fluoridation through its Director of Dental Public Health. This is only a diminution of the role if there is a feeling that there has to be one figurehead for all oral health issues. Arguably it is better to have a broader coalition committed to this agenda.

This leads to a further point – the issue of scale. Professor Wilson suggests the CDOs in the devolved administrations have a broader remit. This is not that surprising when you consider that Scotland has a population of 5.3 million, Wales 3.1 million and Northern Ireland 1.8 million. They are much smaller nations than England, with its 53.9 million inhabitants (www.ons.gov.uk/ons/taxonomy/index.html?nscl=Population). In such a large health system, it is surely good to supplement the CDO role with other experts in policy, oral health and dentistry. Yet in doing this, the CDO role will always remain the most important and influential of all.

Finally, it is worth mentioning that the application process for the new CDO has never had a greater input from dentists with a professional advisory panel drawn from the Royal Colleges and the Dental School Council.

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So for dentists in England, the CDO role continues to provide excellent professional leadership. It has been a privilege working with Barry Cockcroft as outgoing CDO. The new CDO will build on his achievements to provide the leadership and advice to improve NHS Dentistry and the oral health of the nation.

B. Keogh, Medical Director, NHS England; P. Howitt, Dental Policy Lead, Department of Health

Professor Nairn Wilson responds: The response by Professor Sir Bruce Keogh and Peter Howitt is most helpful and reassuring. I anticipate the profession being pleased to learn that the role of the CDO in England has not been diminished and will remain vitally important and influential, and that Ministers will very much value and regard with esteem the new CDO and the perspective brought to the post. It is considered unfortunate and unhelpful to all concerned, however, that the range and extent of the role and responsibilities of the new CDO England, as described by Sir Bruce and Peter Howitt, are not captured in the 'job purpose' as set out in the job description. That said, I believe that the profession will look forward to the new CDO taking interest in issues and developments in all sectors and aspects of dentistry, and working with the many and varied groups and organisations which contribute to dentistry and oral healthcare.

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DENTAL EDUCATION

Oblivion risk

Sir, Martin Kelleher is to be applauded for emphasising the significance of combining appropriate clinical training with an education in medicine and dentistry.[1] Healthcare workers need to acquaint themselves with the latest research developments in their respective domains, or risk being tipped into oblivion. However, in a world inundated with scientific discoveries and over reliance on digital technologies, there is a profound need to illuminate the humanistic side of medicine: benevolence, compassion, care and mercy.

This could not be better illustrated than in the words of Edmund Pellegrino, a pioneer of the teaching of humanities in medicine: *'Medical humanism has achieved the status of a salvation theme, which can absolve the perceived "sins" of modern medicine. The list of those sins is long, varied, and often contradictory: overspecialisation, technicism; overprofessionalisation; insensitivity to personal and sociocultural values; too narrow a construal of the doctor's role; too much "curing" rather than "caring"; not enough emphasis on prevention, patient participation, and patient education; too much science; not enough liberal arts; not enough behavioural science; too much economic incentive; a "trade school" mentality; insensitivity to the poor and socially disadvantaged; overmedicalisation of everyday life; inhumane treatment of medical students; overwork by house staff; deficiencies in verbal and nonverbal communication. It is an art to gain the patient's confidence and trust, and being able to take a complete history of the scientific facts related to the initiation, progression of signs and symptoms of the disease, all are prerequisites for proper diagnosis and treatment.'*[2]

It is equally important to learn how to break an ominous diagnosis or prognosis to a patient, and persuade him/her to accept the reality of great traumas and tragedies and cooperate in choosing the optimal solutions, or accepting the ultimate fate. In summary, healthcare professionals need to balance scientific knowledge with excellent training and communication skills to help patients and their families to navigate through difficult times. There is no substitute for a cordial and caring relationship between the patient and the healer.

M. F. Al Qutob, London

1. Kelleher M. Current controversies in training and/or education of dentists in the UK. *Br Dent J* 2014; **217:** 497–498.
2. Pellegrino E D. *Humanism and the physician.* p 9. Knoxville: University of Tennessee Press, 1979.

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Overproducing dentists

Sir, Judith Husband, in a recent BDA press release, appears to find it comforting that 90% of dentists completing their VT or Foundation year get jobs. I am afraid I cannot share her optimism about these 'green shoots' and I find it desperate that 10% cannot get jobs. Dentistry is a highly vocational and expensive degree to pursue and there is little else you can do with a BDS degree, other than become a dentist.

In Scotland, it is clear we are overproducing dentists significantly.[1] We are heading for significant unemployment and underemployment. Opening a new dental school in Aberdeen has simply compounded the problem. It is time to face the reality that the new school was conceived politically and is protected politically. The new school, with only 20 graduates per year, has never been a success and has sucked human and financial resource from Scotland's two viable dental schools: Dundee and Glasgow. Whilst it will not solve the employment crises we face, it will at least help if the Aberdeen school is closed. How much longer must we pretend that all three schools can continue? Further cuts to Dundee and Glasgow will simply weaken further two excellent schools. It is time now to pull the plug on Aberdeen.

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Dundee

1. NHS Education for Scotland. Dental Workforce Report, December 2014.

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