EDITORIAL

The practical mode of teaching

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Wackford Squeers, the grotesque schoolmaster of Dotheboys Hall in Charles Dickens' novel *Nicholas Nickleby* described his method of education to the eponymous hero thus: "This is the first class in English spelling and philosophy. Now, then, where's the first boy?"

"Please, sir, he's cleaning the back-parlour window," said the temporary head of the philosophical class.

"We go upon the practical mode of teaching, Nickleby; the regular education system. C-l-e-a-n, clean, verb active, to make bright, to scour. W-i-n, win, d-e-r, der, winder, a casement.

When the boy knows this out of a book, he goes and does it."

To say that the *BDJ* has a similar philosophy isn't too far from the truth, although we strive to be rather better than the fabled Yorkshire schools of the Victorian era; and we do attempt to spell correctly. But in essence part of our goal is to translate science into practice and to provide, if you will, a practical mode of teaching in clinical and other skills. Often this is manifest in reinforcing existing techniques or by publishing research that sets out to test their boundaries. Occasionally there is something genuinely new which requires description, explanation and examples of practical application. Most recently this has been the case with the 2017 World Workshop Classification system for periodontal and peri-implant diseases and conditions.

These new guidelines have reimaged our former concept of periodontal disease, diagnosis, prevention and treatment and are of fundamental importance to all clinicians. The guidelines were developed to accommodate advances in recent knowledge from biological and clinical research and for the first time detail a classification system that gives clear definitions of periodontal health and gingivitis. This they do for patients with an intact periodontium and those with a reduced periodontium

due to periodontitis or other causes. To ensure a complete diagnosis of a patient with periodontitis, staging and grading of the disease are now included with an explicit distinction of severity/extent of periodontitis (stage) and disease susceptibility/progression (grade). In order to provide the necessary update we have published an overall explanatory paper and in this and the next three issues, case examples of practical implementation of the guidelines, to which we have added CPD.¹

On the theme of the practical mode of education the GDC has just published a literature review that it commissioned from the Association for Dental Education in Europe on CPD.² Now it is laudable that the GDC decided to do this and equally useful to have the distillation of data from 184 papers on the

is also enhanced by reflective practice, but the literature confirms that these skills are not inherent, and professionals need to be trained in how to reflect well.

The problem here is, not surprisingly, resources; time and money. However desirable qualitative learning might be, who creates, vets and adjudicates on the quality of the offerings? Similarly, who assesses the value of CPD to the participant, in turn to the participant's patients, and indeed the extent to which that qualitative learning is, or can be applied? Who is to pay for this? Does it come from the annual retention fee (I see no reference to it in the GDC's apparent hoarding of a war chest of reserves against future misdemeanours)? From the NHS (no mention of this in contract reform)? From our practice expenses, profits

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subject internationally and from other professions and disciplines, but how much further does it realistically drive us forward? The conclusions are not substantially different from those which either we might expect or which we might have aspirations to work towards. There is a clear shift from regulators, both inside and outside health, towards qualitative-based CPD models and away from quantitative-based models, which tend to focus on the number of CPD hours completed. This shift is thought likely to be linked to the inability of quantitative-based models to drive improved performance or patient care. The take-up of CPD activity should largely be driven by its relevance to patients or practice and the inclusion of interactive elements. CPD activity

and spare time? Probably. Ultimately, the patient will have to pay and one can argue sensibly that if it is a matter of safety, of best practice and of good care then it is right that this should be the case.

I wonder what Mr Squeers would have made of the mode of reflective learning? Perhaps that you could see through it, like a newly cleaned win der. ■

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1. Dietrich T, Ower P, Tank M *et al*. Periodontal diagnosis in the context of the 2017 classification system of periodontal diseases and conditions – implementation in clinical practice. *Br Dent J* 2019; **226**: 16-22.
2. ADEE. A Review of the Literature on Continuing Professional. GDC. Available at (CPD) <https://www.gdc-uk.org/api/files/181205%20Full%20Report%20Review%20of%20the%20Literature%20on%20CPD.pdf> (accessed January 2019).