Common reasons for choosing dentistry as a vocation in the UK include having a fulfilling career where, after five hard years invested at dental school, one could be rewarded with a high probability of employment and the opportunity to marry scientific knowledge with practical hands skills to provide for the public, either on an NHS or private basis or both. A-level students have high standards to achieve and maintain to gain admission to undergraduate programmes. Towards the end of their training, young dentists may feel like they are about to enter a minefield on graduation.

In the last year of dental school, those wishing to enter vocational training are pitted against each other, then ranked nationally and allocated a training position according to their performance in that selection process. Whatever happened to being interviewed by a future employer and performing at that more personal, mutual assessment level? It appears that the system is becoming increasingly mechanistic; a conveyor belt if you will, where a college student enters, is educated in a cost-effective manner, and assessed and allocated around the country.

The issues involved in undergraduate training, as opposed to education, have been topical recently. Dentistry has both educational and training aspects. Undergraduates need to undergo appropriate volume-based improvement of their diagnostic, planning, and hand skills, linked to appropriate knowledge. Pure education will never be enough for a professional where one is more likely to be judged against a technical outcome yardstick than on purely theoretical knowledge. Dental schools providing this requisite training or are they being failed by the environment that they now have to learn the practical, technical aspects, as well as some helpful clinical tricks of the trade? The fault seems now to lie more in the lack of appropriate nurturing of these talented and capable individuals, as opposed to unfairly criticising their nature, which does not appear to be valued to the same level as other professions. We tend to underrate and understate ourselves compared with other professions. Doctors tend to be looked upon favourably—there when patients need help most. Lawyers are viewed in a different, more formal way, especially when one is more likely to be found in an environment more difficult for the younger generation of dentists.

As such, “defensive dentistry” can induce and expensive in the UK. Somewhat ironically, NHS medical services are free at the point of delivery and NHS dental treatment is also free. However, every patient coming to our dental colleges where there is no bill for a hysterectomy or a hip replacement, but they have to pay £220 for a spoon denture. As such, the perception by the public and the media may always be more negative than positive, and the government may play on this to squeeze the pips of goodwill out of dentists until nothing is left.

Again, the NHS UDA system may be blamed for not rewarding the management of plaque-associated disease to the level it merits, and because of that perception such individuals may hunt for more supplemental opportunities. Further specialist training is seemingly London-centric and expensive. It looks increasingly unlikely that a UK graduate with five years of debt in tuition fees will be able to afford to train and develop comprehensively if he or she desires this without falling deeper into debt. As such, these postgraduate specialist courses are popular among overseas students, whose large fees are welcomed by academic units. Unfortunately, the overall experience and skill set within these shores is likely to decrease as a result of much of this postgraduate effort with a net increase for countries abroad where they will then bring that expertise.

As such, “defensive dentistry” can override intrinsic motivation to treat deserving and unfortunate patients and thereby discharge our wider duty to society. This increase in indemnity premiums is unlikely to have been instigated by a waive of amalgam carvings without secondary fissures by dental foundation trainers. An increase in procedures such as implants, short-term orthodontics and elective cosmetic dentistry is more likely to have had an effect on premiums for all.

As a growing number of settle-
m ents become increasingly sizeable, those possibly avoidable mishaps by the more senior, supposedly experienced, among us make the environment more difficult for our junior colleagues. There is so much overt dental disease and a great need for this to be treated using predictable methods, and it baffles me that despite this, many young dentists see opportunities to supplement their income and skill set with high-end, high risk procedures more likely to lead to litigation well before the basics of proper, proven dentistry have been learnt, attained and honed. Unfortunately, the skills they may feel or believe they want to achieve are not routinely what they probably need most or possibly what potential employers really want and likely what the public requires. Recently, a colleague in private practice about the CV of a young graduate with only four years of experience. He had gained “qualifications” in facial aesthetics and cosmetic dentistry, had completed a course in super-quick orthodontics and was studying for an MSc in metal screws. My friend commented, “If I take him on, who’s going to do the dentistry, the therapist?”

The NHS system is not the only daunting aspect of this brave new world that young dentists are entering. Dental litigation in the UK is rife and ever increasing and, as expected, indemnity premiums are increasing. Young dentists may well be nervous and risk adverse; if

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provement of oral health in those countries less developed than our own. Despite this a balance should be struck. Rewarding those hard-working, committed and talented of home candidates with scholarships for further training is common overseas.

Spare a thought...

A young graduate recently told me about his experiences of apply-
ing for jobs. Three people, two of whom were friends, had applied for a position in the North East. The interviewing principal came into the waiting room and said that he was not interviewing, as they all had very similar qualifications and credentials. All he wanted to know was who of the three would take the lowest sterling amount for a UDA.

He promptly gave them three envelopes and asked them to write down the magic number. One applicant wisely got up and left. Two of the friends remained and seemingly agreed to write down the same amount. Unfortunately, the friendship came to a cata-
strophic end when one applicant broke the pact and wrote a lower amount. He got the job and the principal pocketed the difference. The conscientious and capable, yet unsuccessful, candidate eventually relocated to Australia, the reservoir to which some of our UK talent drains.

When I heard this, my jaw dropped and my heart sank. This story smacks of a profession being squeezed from all sides, resulting in such acts of desperation. Imagine if you will dentistry in the UK as a sand-castle and we dentists each a grain of sand. When building a sand-castle, gently cupping the sand in a supportive way, as op-
posed to squeezing it tightly, is a more efficient way of dealing with it. Squeezing it too tightly results in grains escaping between the fin-
gers, and by the time one reaches the castle site, there is nothing left in one’s hands, but a few grains. It appears that the hands that are designed to facilitate and accom-
modate our efforts to treat patients are gripping too forcefully, re-
sulting in frustration and anger. Our young colleagues desperately want to build a career in this diffi-
cult and hazardous environment. Spare a thought for them and help if you can.

Editorial note: A list of references is available from the publisher.

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