Dental Schools Council response - FINAL

GDC Learning Outcomes
Consultation Questions – responses due by 3 December 2010

http://www.gdc-uk.org/News+publications+and+events/Consultations/Current+consultations/Consultation+on+learning+outcomes.htm

Guidance

There is both a full publication, with guidance and a summary table containing the learning outcomes. The approach taken focuses on:

- Safety and quality of care for patients
- Current and future oral health needs
- The full range of knowledge, skill and attitudes/behaviours that a student or trainee must demonstrate to the level appropriate for registration i.e. professionalism, communication, clinical/technical and management and leadership skills

The outcomes are written in way that is intended to provide a balance of detail for consistent interpretation, flexibility for responding to developments in practice and encouraging innovation among education and training providers.

Education providers will be expected to develop more detailed learning outcomes from these higher level outcomes.

Is the supporting guidance on pages 7-13 clear? (the full GDC quality assurance policy and process will be contained in separate guidance)

~~Yes~~ **No**

If not, please indicate why.

Overall the supporting guidance is clear, but some clarification would greatly improve the document.

Page 7	This document describes the ~~outcomes~~ **knowledge, skills and attitudes** that an individual must be able to demonstrate.
Page 8	This mentions a rounded professional, competent clinician and work as part of a team. Whilst these are laudable, this gives the false impression that the new graduate will be capable of working on their own, in isolation. We do not want a new graduate to have a false impression of their capabilities. Guidance from more experienced colleagues is part of a clinician's continuing development.

	The first aim (clinical) is unclear. It is important that the generic skills are identified, and must include for example information synthesis, decision making and technical skills, often at high level
Page 9	The Registration Overview diagram could be improved by adding an arrow to indicate those removed from the register. Under 'Roles and Responsibilities', the statement 'it is the responsibility of training providers to devise qualifications', would be better expressed as 'to devise curricula' Under 'Roles and Responsibilities', the seventh bullet point relating to patient feedback seems misplaced as there is so much more that is needed to inform student development. The collection of meaningful patient feedback has, in the experience of dental schools, been difficult to achieve. When requested, it has been almost universally and overwhelmingly positive. In part, this is probably a function of patient gratitude for service.
Page 10	The statement 'students must have the opportunity to practise on a wide range of patients – of all ages and including those with special care requirements, with a wide range of treatment needs' needs clarification and clear learning objectives. For example all ages – from birth to senility? Special care requirements – bi-polar disease to terminal Neoplasia? This asks a lot of an undergraduate – and it would be more appropriate to expect them to know the appropriate referral pathways. Under 'Student fitness to practise', demonstrating professionalism is an excellent aim, but the realistic assessment of professionalism as an outcome is more problematic.
Page 13	The first three of the four domains are excellent. However the title of the 'Management and leadership' section does not fit well with its contents – we cannot expect a new graduate to show the management skills of a leader. We do not believe it possible for 'teaching providers to design assessments so that they assess students against all the required learning outcomes' – in part because many of the outcomes are not assessable, but also because many outcomes are written in an ambiguous way or with inappropriate action verbs.

Regulatory role

Is the regulatory role of the GDC in relation to dental education explained fully?

~~Yes~~ **No**

If not, please indicate why.

The document does address the outcomes that dental schools must achieve, however it does not make clear how the GDC proposes to check that dental schools are achieving these outcomes. In the past, there has been some variation in the approach to GDC school

inspections, and it would be helpful if this document included details of how the GDC proposes to conduct future reviews.

On the one hand, statement such as 'The GDC's role in relation to education and training is to ensure that those who join our registers are fit to practise at the point of registration, and remain so throughout their working lives. The GDC's responsibility is therefore to define the outcomes required, and to make sure they are met through the education, training and assessment process, by future registrants.' seem to provide precision, along the lines of TFFY 2002; on the other 'Where outcomes are worded identically between registration categories it is expected that, as with all the other outcomes, they should be delivered as appropriate to the category in question', leaves too much open to interpretation and thus questions the standard against which the GDC will regulate.

Content, structure and format of the learning outcomes

The aim is to develop a rounded professional who, in addition to being a competent clinician or technician, will have the range of professional skills required to begin working as part of a dental team and be well prepared for independent practice. Patient needs and safety are central to this.

How would you respond to the following statements?

The outcomes broadly reflect the level required of a new registrant.

~~Strongly disagree~~ **Disagree** ~~Neither~~ ~~Agree~~ ~~Strongly agree~~

Please give reasons for your answer.

Throughout the document, there is a degree of inconsistency in the level of detail provided. Quite a number of outcomes are ambiguous, which may be deliberate to enable schools to innovate and set more precise outcomes. However this does not explain why some outcomes are more specific. The outcomes stated in the Clinical section, notably 1.1.1 – 1.1.10, are insufficient and require much more detail. The use of 'describe' suggests that an undergraduate, at the point of registration, can recite aspects of disease management without necessarily demonstrating understand.

The outcomes **broadly** reflect the major minimal requirements of a new registrant, however as the minimal requirements, the learning outcomes are far too often placed too low on Bloom's Taxonomy. There is too much emphasis on dental graduates 'describing' and far too little emphasis on 'explain, evaluate, critically evaluate, synthesise, apply findings and recognise', which is in poor contrast to the sister document *Tomorrow's Doctors (2009)*. There could be considerable laxity in interpretation of many of the learning outcomes as they are currently presented, and have a profound influence on the curriculum content to satisfy the learning outcome. Such openness to interpretation must surely challenge any attempt by a Regulatory Authority to require a given standard of performance of the dental graduate.

It would be helpful to determine and identify a small hierarchy of verbs that are used consistently, and to try to avoid repetition. Each verb would automatically imply understanding of the science associated with the disease, tests, drugs etc. It would imply that all stages were undertaken in a professional manner, putting the interests of the patients first. This would avoid the need to repeat statements that underpin professionalism.

Suggested verbs:

Treat This would mean that, by graduation, the student should be able to examine the patient, undertake all the required diagnostic tests, arrive at diagnosis, formulate a treatment plan and then execute the treatment.

Manage This would mean that, by graduation, the student should be able to examine the patient, undertake diagnostic tests where appropriate, arrive at a provisional diagnosis and decide whether to monitor, treat or refer.

Refer This would mean that, by graduation, the student should be able to examine the patient, arrive at a tentative diagnosis, and recognise the need to refer to secondary care.

Understand This would be for parts of the curriculum where there is no management or treatment involved.

Examples:

Should be able to **treat** dental decay
Should be able to **treat** toothache
Should be able to **treat** routine periodontal disease
Should be able to **manage** advanced periodontal disease
Should be able to **manage** oro-facial pain
Should be able to **manage** abnormal mucosa lesions
Should be able to **refer** suspected fractures of the jaw
Should be able to **refer** cases of suspected child abuse
Should **understand** the role of the General Dental Council
Should **understand** levels of proof in relation to disease

It would also be helpful if the GDC was to establish and define a hierarchy of levels that indicate the level of knowledge and skill required. It is interesting that this was in *The First Five Years*. Unfortunately only three levels were defined (be competent at, have knowledge of and be familiar). This was unworkable, but the concept was a good one because it defined the level. The following five examples may be more appropriate:

Be competent at – implies that they can do it themselves without prior advice
Becoming competent at – means that they can do the procedure, but should seek advice (from VT trainer) before starting
Have experience of – means that they will have undertaken the procedure but require further supervision
Have seen means that they should have seen the procedure, but would not need to have performed the procedure themselves
Be aware of means that they need to know about the procedure (from a book or lecture)

The expectations under the Management and Leadership criteria appear to us to be high and make no acknowledgement of the traditional shared responsibility in this area between dental schools and the postgraduate deanery. The Outcomes need to put the undergraduate curriculum next to the role of VT, CPE and specialist training.

The learning outcomes framework meets the needs of patients.

~~Strongly disagree~~ **Disagree** ~~Neither~~ ~~Agree~~ ~~Strongly agree~~

Please give reasons for your answer.

Since it seems impossible to define the level of the new registrant, it is impossible to say whether the learning outcomes meet the needs of patients.

Content, structure and format of the learning outcomes

There are four categories of learning outcome (clinical, communication, professionalism, management and leadership).

For each, please state whether you agree or disagree with the following statement:

The category contains the skills, knowledge and behaviours required to practice as a newly registered dental professional.

Clinical

~~Strongly disagree~~ **Disagree** ~~Neither~~ ~~Agree~~ ~~Strongly agree~~

If you disagree please provide examples and suggestions below.

A major deficiency in the Learning Outcomes document is the lack of any attempt to differentiate between the QAA's 'Framework for HE qualifications in England, Northern Ireland and Wales' and the equivalent document for Scottish providers which describes the descriptors for courses at Levels 4-8.Dentistry is taught through a continuum of levels depending on the subject, and during the final two years many aspects are delivered to dental students at Level 7 (Masters). Few of the Learning Outcomes in this document as written could be classified beyond a Level 4.

The levels of the learning outcome lack the appropriate challenge – and thus they do not reflect the skills, knowledge or behaviours required to practise as a newly registered dentist. As dental schools – and as patients – we should expect more of dental graduates that what is outlined in this document. In particular it will be important to add emphasis to the development of students' research skills and skills for critical analysis, which are important for lifelong learning and also to prepare graduates for employment as students who wish to pursue an academic career or a career in teaching hospitals should be encouraged and supported to do so. Although the broader system of learning outcomes is understood to be 'overarching', in terms of regulation, the lack of **any** competencies – now commonplace in postgraduate medical and dental training

– or learning objectives puts at risk the GDC's authority to determine the suitability of a training programme to Registration.

Too many key words are used interchangeably within the Outcomes document, and as a result, the learning outcomes are open to interpretation. The document is disjointed and repetitive, and requires education providers to make an educated guess as to the level of knowledge and skill required, for example:

1.1.2 Describe oral diseases and their relevance to prevention, diagnoses and treatment
1.9.2 Manage oral mucosal disease and refer when and where appropriate
1.10.2 Identify oral mucosal disease and refer where appropriate
1.10.3 Identify all stages of malignancy, the aetiology and development of tumours and the importance of early referral for investigation and biopsy
1.10.5 Undertake pre-operative assessment, implement appropriate management techniques, including referral, and carry out appropriate post-operative care.

There is specific mention of oral mucosal disease and malignancy, but no mention of bone lesions, cysts, odontogenic tumours or salivary disease. This illustrates the lack of balance throughout the document – with specific details of some subjects, and no mention of others. This raises the question whether this reflects the poor construction of the Learning Outcomes, or if it indicates the relative importance of topics?

There needs to be careful appraisal of the relative weight of individual disciplines. For example there is a great deal of detail about orthodontics, but no mention of the child patient, biology, microbiology, genetics, biochemistry or the particular skills needed to care for child patients. There needs to be a requirement to understand critical analysis, and to demonstrate research skills.

Additional comments:

1.2.3 How can students 'manage' clinical and laboratory investigations? They must be able to implement them, understand them or interpret them
1.2.5 Is there an accurate assessment tool to certify that students can assess patients' levels of anxiety?
1.3 Add the outcomes that a registrant should be able to accurately diagnose the patient's condition, as well as generate a differential diagnosis **or** refer for specialist advice
1.4.2 Delete or define the range of alternative treatments. Reference to the 'range of orthodox complementary and alternative therapies' is at odds with an evidence based approach.
1.4.3 valid and informed consent can also be taken, under certain circumstances, from parents, carers or guardians, and students should know this.
1.5 There is no mention of disease prevention, rehabilitation of form and function, and maintenance of health. These are major goals of dentistry and their omission is unacceptable in an outcomes-based document.
1.6.5 This requires clarification on the level of 'guidelines' – whose? What level of evidence? Evaluated by what type of body? (NICE yes, an individual implant company, no!)
1.6.6 This is ambiguous – should students also, by implication, be able to prevent medical emergencies? An additional outcome would be 'Identify medical problems, physical and mental disability or psycho-social problems that could affect provision of dental care, and amend treatment plans or patient management appropriately'
1.6.8 Delete. This is not an appropriate – nor assessable – outcome for an undergraduate.

1.7 Mention of other acute conditions is omitted – for example salivary gland infections, mucosal trauma, haemorrhage

1.9 The outcomes related to periodontal disease are very detailed, although there is no mention of periodontal surgery. This is in stark comparison with 1.12 where conservative dentistry is covered in two sentences

1.9.1 Move to 1.10 (refers to mucosal disease)

1.9.2 Delete. This is general patient care, not periodontal – and is repeated in 1.10.2

1.9.5 The implication is that screening tools can be used to monitor and record periodontal health/disease – this is false, as screening tools (such as Basic Periodontal Examination) simply identify that patients have a problem, or otherwise.

1.9.7 Amend to 'Evaluate, for individual patients, the need for more complex treatment, and provide non-surgical or surgical periodontal treatment, or refer appropriately'

1.10.3 Delete the word 'all'

1.10.4 The appropriate level must be clarified. Certainly yes, at the dento-alveolar surgery level, but less so with more extensive hard tissue surgery and surgery away from the head and neck

1.10.5 The appropriate scope must be clarified. For all procedures? How should this be measured?

1.10.8 Requires clarification. Rather than say 'manage' unerupted teeth and roots, state e.g. that graduates should be able to remove (some or all) unerupted teeth and roots

1.11.6 Clarify definition of 'limited'

1.12 This section needs to be greatly strengthened by stating the first requirement to be to create an oral environment where restoration and tooth replacement is worthwhile. Statements regarding restoration and replacement must be prefaced with a clear policy that restoration and rehabilitation should be carried out to a standard consistent with long term survival of the restorations and prostheses

1.12.4 Clarify what is meant by non-surgical treatment? Is pulpectomy not a 'surgical' treatment? Are students thus not expected to be able to carry out endodontics?

2.1 – 2.5 Population based health and care – this is overkill. There should be an overview of principals, an awareness of demographics and an understanding of population needs.

Communication

~~Strongly disagree~~ ~~Disagree~~ ~~Neither~~ **Agree** ~~Strongly agree~~

If you disagree please provide examples and suggestions below.

The Dental Schools Council supports the outcomes under the Communication domain, recognising the importance of dental graduates to be able to communicate effectively with patients and with other professionals in the dental healthcare team.

1.3 Dental graduates should have an understanding of the costs, but there is probably limited realism at this stage in training.

2.2 Students are informed about the dental team and work in teams, but we would not expect them to participate in the appraisal, assessment training and review of colleagues. Linked to this, we are surprised that the GDC sees no role for registrants other than dentists to be involved in appraisal of colleagues.

Management and Leadership

~~Strongly disagree~~ **Disagree** ~~Neither~~ ~~Agree~~ ~~Strongly agree~~

If you disagree please provide examples and suggestions below.

This domain will be the most difficult to accurately incorporate into the undergraduate curriculum and assess accurately. Indeed, much of the content in this section the student will become familiar with only after graduation. Historically, training of Management and Leadership has been shared with VT training programmes, and this is where much of this domain should be delivered. Clarification of the level required during the undergraduate programme would be helpful.

Additional comments:

1.7, 1.8, 2.4 Delete. These roles are entirely within the area of Dental Foundation Training, and cannot be assessed in undergraduate programmes

2.6 Delete. As students are not registered and not autonomous, they cannot 'delegate'

2.8 Delete. This cannot be assessed as an outcome.

3.1 – 3.5 These outcomes are inappropriate at undergraduate level. Although a graduating dentist should have some understanding of these issues they cannot be expected to 'apply' systems or to 'comply' with national requirements. These outcomes and their assessment are more appropriately managed in Foundation Training.

Professionalism

~~Strongly disagree~~ ~~Disagree~~ ~~Neither~~ **Agree** ~~Strongly agree~~

If you disagree please provide examples and suggestions below.

It is considerably harder to use this section in a similar manner to the other domains, as most of what is outlined here relate to values rather than outcomes. As all outcomes need to be assessed, trying to assume these 'values' are 'outcomes' will pose problems that currently have no form of resolution. Education providers will either fail here – or the failings with ability to assess these values will be brushed under the carpet – and neither of these actions are appropriate. The difficulties of assessing professionalism outcomes (as opposed to unprofessionalism) needs to be recognised and this section then revised accordingly.

All that can reasonably be expected of education providers is that professional behaviours, as outlined in the Standards for Dental Professionals, are monitored, and Student Fitness to Practise procedures are followed where those behaviours fall short

4.4 Commitment to lifelong learning is aspirational, and cannot be assessed as an outcome of the undergraduate curricula

Content, structure and format of the learning outcomes

The learning outcomes in each of the four categories or domains (clinical, communication, professionalism, and management and leadership) should be seen as integrated and supporting each other, with the clinical skills, underpinning scientific knowledge and evidence based practice forming the central core. They should be applied as relevant to the registration category, and importantly, in relation to patient care. The outcomes also clearly relate to the GDC 'Scope of Practice' and other Standards documents. Some signposting has been provided within the publication, this is not exhaustive.

There are four overarching outcomes which should be demonstrated throughout education and training. These form some of the key principles of effective and professional practice, running through all the domains and are the same for all of the registration categories. The outcomes are grouped within each category under subheadings. For example, in the clinical category the learning outcomes have been separated into two sections – 'Individual patient' care and 'Population based health and care'. The individual patient care section begins with a section on the 'Foundations of practice' then follows the patient journey, including the stages through assessment, diagnosis and patient management.

Considering the structure of the learning outcomes please answer the following question (please consult the summary table):

Are there any subheadings that are: missing, inappropriate, at the wrong level?

~~Yes~~ No

If you think there are, please provide examples and any suggestions for alternatives in the box below.

There is excessive repetition within the content of the various domains which might be as much a feature of structure as anything else.

Considering the content of the learning outcomes please answer the following question (please consult the summary table):

Are there any outcomes that are: missing, inappropriate, at the wrong level?

Yes ~~No~~

If you think there are, please provide examples and any suggestions for alternatives in the box below

See earlier detailed comments.

Please state whether you agree or disagree with the following statement:

The outcomes are clear. 1

Strongly disagree Disagree Neither Agree Strongly agree

Please list any outcomes which could be clearer. Alternative suggestions for wording are welcome.

Please state whether you agree or disagree with the following statement:
The outcomes are measurable and therefore assessable?

~~Strongly disagree~~ **Disagree** ~~Neither~~ ~~Agree~~ ~~Strongly agree~~

Please list any outcomes which could be improved and why. You can offer alternative suggestions for wording

For any education provider, it will be difficult to determine the level that should be achieved for nearly all the outcomes. Some consideration should be given to providing guidance on this matter.

Content, structure and format of the learning outcomes

The document contains outcomes for all of the registrant categories to facilitate the notion of team working. The outcomes are presented in four domains which all underpin each other with the clinical domain being the core ie clinical, communication, management and leadership, and professionalism. The structure and subheadings within these domains are consistent between registrant categories, where appropriate and reflecting their scope of practice.

Please consult the summary table showing all the outcomes for each of the registration categories in answering these questions.

How would you judge the format and presentation of the guidance? 1

~~Excellent~~ **Good** ~~S~~atisfactory Poor Very Poor

Do you have any comments on the format or presentation of the guidance?

Team working is a key part of delivering effective patient care. Each part of the dental team is responsible for carrying out specific roles and activities through the cycle of care, both under supervision and independently.

Is the integration between the categories of registrant shown in a helpful way?

Yes

~~No~~

Please outline the reasons for your answer.

The outcomes are intended to be delivered at a level appropriate to the registrant category. It should be noted that some identical outcomes appear in more than one category, particularly in the categories supporting the clinical outcomes. For these outcomes, there may be more or less complexity or responsibility expected in the delivery of such an outcome, depending on the scope of practice and role of the particular category of the dental team.

Are the differences between each registration category clearly defined?

~~Yes~~ **No**

If no, outline any areas where there needs to be greater or lesser differentiation and the reasons why.

Many of the learning outcomes are shared across the different registration categories which is not unexpected. However, because the level that is required for each learning outcome for each category of registrant is not articulated, then the document could be read as indicating that the same level is required for all.

Equality and diversity

There are requirements in the guidance section of the publication around equality and diversity issues - page 9 under 'Role and responsibilities of training providers' and page 10 'Role and responsibilities of the student'. The content of the learning outcomes also outlines expectations around the dental professional in each of the four domains (clinical, communication, professionalism, management and leadership), not just regarding the range of clinical expertise and judgment but professional behaviour and communication skills. You may wish to think about how the outcomes impact on particular groups eg patients, the public, employers, training providers, students and healthcare professionals.

Considering both the introductory guidance and the content of the learning outcomes please answer the following question:

Are there any issues relating to equality and diversity which need to be addressed?

~~Yes~~ **No**

If yes, please indicate what they are.

If you are not an education provider please go to the 'Further comments' section.

Implementation

The GDC role is to set the learning outcomes and then quality assure their assessment. The GDC would expect and encourage there to be some variation in implementation between education and training providers while keeping an overview. It is for the education providers to determine the detail in their curricula and training programmes and the format of the assessments

Is the level of detail appropriate for consistent interpretation by education and training providers i.e. in order to deliver broadly equivalent training and assessment?

~~Strongly disagree~~ **Disagree** ~~Neither~~ ~~Agree~~ ~~Strongly agree~~

Please give examples where there may be an issue.

We agree with some aspects of the general statement that 'there is a greater focus on patient needs and safety, and professionalism than the previous curriculum'. However, despite this ambition, we maintain that a sound education in appropriate biomedical sciences underpins clinical training and practice, and therefore impacts upon patient safety. Our interpretation of the Outcomes document suggests less emphasis on, and prescriptive requirement for, some aspects of biomedical sciences teaching such as biochemistry and microbiology, both of which are fundamental to understanding of common oral diseases and therefore required for patient needs and safety. Our interpretation of the documents also suggests less emphasis on the teaching of Human Disease, which we also consider to be detrimental to patient needs and safety. The many omissions raise questions as to whether these are deliberate and therefore teaching of e.g. biochemistry, cysts, salivary gland disease, are no longer necessary.

Although much of the content is similar to the requirements set out in the previous curricula, changes to training programmes will be necessary. This is due to the refocus of the outcomes on patient care and professionalism and the requirement for students to have successfully demonstrated all the outcomes by the end of the training programme. In particular, training providers may need to adapt their assessment models. It is helpful to note here that the GDC will be separately consulting all training providers on a suitable implementation timescale and new quality assurance process.

How achievable are the outcomes within current pre-registration training mechanisms?

~~Achievable~~ **Achievable but time and resource investment needed**

~~Unachievable~~

Please indicate any areas which may be difficult to achieve and include reasons.

The set of learning outcomes provide only the most general overview of dentistry and dental education. Some of the outcomes are clear, but many are written as objectives with inappropriate action verbs for example 'recognise', which could in themselves provide confusion in understanding the depth of knowledge or competence required of the graduate – whilst seemingly dictating the method of assessment. The lack of clarity will provide for uncertainty amongst dental education providers, and could inadvertently reduce the quality of UK dental graduates depending on the interpretations used.

The assessment methods may (rightly) vary between dental schools, but the Learning Outcomes, by using active verbs throughout, come close to dictating the process of delivery and assessment of outcomes. The document would be more useful if the outcomes define at a higher level the knowledge, skills and attributes needed to be a newly qualified professional. More specific outcomes statements then become the responsibility of each school. In this way, schools can more clearly define outcomes at course or module level, using appropriate active verbs, and thus more clearly align outcomes to local learning and teaching methods, and to assessment criteria and methods.

Please see comments relating to the distinction between 'values' and 'outcomes', and the associated difficulties with measuring these as assessments.

Further Comments

Please provide any further comments you may wish to make on the draft learning outcomes for registration.

This response reflects the views of the Dental Schools Council relating to dentistry, on the understanding that other professional groups will reflect their own views.

The content and format of the Learning Outcomes represents a major departure from *The First Five Years* (2002), and continues to be of surprise to the Dental Schools Council, despite previous comments shared with the GDC. We are uncomfortable with the use of the Learning Outcomes in its present form as a basis for a regulatory document.

The Learning Outcomes lack understanding of clinical academia, or the teaching of clinical dentistry to undergraduates and postgraduates. The format of *Tomorrow's* Doctors could be taken as a useful pointer, especially in outcomes relating to basic sciences, scholarly activity and scientific endeavour and research. The four key domains of clinical, communication, management & leadership and professionalism provide an excellent framework but we raise strong concerns that in its current form, the Outcomes place insufficient emphasis on the acquisition of core clinical skills. There is a lack of mention of the science underpinning dentistry, and less emphasis on the teaching of Human Disease, both of which could be detrimental to patient needs and patient safety.

It is useful that learning outcomes for the dental team are linked, and that the importance of the differences between pre-registration, registration and revalidation is highlighted. The summary table is excellent – but could be improved if the learning outcomes common to all groups are

arranged across the page and similarly numbered to facilitate cross referencing. Where similar skills are expected, it would be helpful to use similar learning objectives.

The Outcomes would benefit from a more outward facing approach, with reference to the work done in Europe under the umbrella of ADEE regarding the Profile and Competencies of the Graduating European Dentist, and also convergence in higher education, student mobility and exchange, the UK framework for higher education qualifications, and level descriptors. The GDC must have an interest in this because of the freedom to work in any country in the EU by EU citizens.

It may be deliberate, but there is no mention of the role of universities in the Learning Outcomes document. Also, at the very beginning of the document (P7, line 1) it states "This document describes the outcomes that an individual must be able to demonstrate ..." with no parallel statement related to outcomes that an education provider or university must demonstrate. This suggests that an individual could meet the outcomes from a range of providers, including overseas, and if they could demonstrate compliance, could then be registered. There is no stated requirement for a university education or a degree. Other providers (for example the Colleges, private providers) could easily try to compete in the market and undermine the importance of dentistry as a university degree and the role of the Schools. Universities play a vital role in the development of dentistry, enhancing the quality of patient care and satisfaction through research and scholarship. If university based dental schools are not involved in the advancement of dentistry, the profession will be vulnerable to reduced standards and therefore potentially compromising patients. The General Dental Council should clarify their position on this.

The current laxity in interpretation may provide for innovation, flexibility and diversity in dental programmes throughout the UK, but we have considerable concern that the lack of clarity in prescribed learning outcomes will provide for uncertainty within dental education providers aiming to inculcate the most important characteristics, knowledge and competence into the dental student. This could inadvertently reduce the quality of UK dental graduates from some schools depending on interpretations used.

Getting involved

Depending on the feedback we receive, the GDC may need to carry out further development work to explore issues in more detail.

Would you be willing to contribute to further development work on the new learning outcomes? (eg taking part in a group discussion/focus group)

◉ **Yes** ○ ~~No~~

If yes, please provide contact details below.

admin@dentalschoolscouncil.ac.uk	020 7419 5494
Professor William P Saunders (Chair)	Dean of Dentistry, School of Dentistry, University of Dundee
Professor Farida Fortune (Treasurer)	Dean of Dental Studies and Director of Clinical Academic Unit, Barts and the London School of Medicine and Dentistry, Queen Mary
Professor Jeremy Bagg	Head of Dental School, University of Glasgow

Professor Donald Burden	Director, Centre for Dental Education, Queen's University Belfast
Professor Richard Ibbetson	Director, Edinburgh Postgraduate Dental Institute
Professor Elizabeth Kay	Dean, Peninsula Dental School, Peninsula College of Medicine and Dentistry
Dr Margaret Kellett	Dean/ Director, Leeds Dental Institute, University of Leeds
Professor Mike Lewis	Dean of School of Dentistry, Cardiff University
Professor Philip J Lumley	Director and Head of School of Dentistry, University of Birmingham
Professor Iain Mackie	Head of School of Dentistry, University of Manchester
Professor Lawrence Mair	Head of the School of Dentistry, University of Central Lancashire
Professor James Newton	Director and Head of Dental School, School of Medicine and Dentistry, University of Aberdeen
Professor Stephen Porter	Director, UCL Eastman Dental Institute
Professor Jonathan R Sandy	Head of School, School of Oral and Dental Sciences, University of Bristol
Professor Paul Speight	Dean, School of Clinical Dentistry, University of Sheffield
Professor Jimmy Steele	Head of School, School of Dental Sciences, University of Newcastle
Professor Nairn H F Wilson CBE	Dean and Head of Dental School, King's College London Dental Institute
Professor Callum Youngson	Head of School, School of Dental Sciences, University of Liverpool