Communication and professionalism skills of a new graduate: the expectations and experiences of dental foundation trainers

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Abstract

Aim: The aim of this study was to investigate dental foundation year 1 (DF1) trainers' expectations of the dental graduate specifically in relation to non-clinical (professionalism and communication) skills and to explore whether these expectations were being met.

Method: In the UK, dental graduates undertake 1 year of foundation training prior to being permitted to undertake NHS practice. An online survey was distributed to DF1 trainers via all 11 English deaneries and the Northern Ireland deanery. Demographic information and a general view of trainers' expectations of a new trainee were collected. Specific questions relating to six generic trainee problems were followed by 11 ability statements where trainers indicated their expectation of a trainee's ability to perform the skill on a 5-point scale (*on own with confidence–unable to undertake*). Statements were repeated and trainers were required to respond using the same scale in relation to experience of their current trainee.

Results: Five hundred and ten (53%) trainers completed the questionnaire with no missing data. Expectations were high with almost 50% of trainers expecting a new graduate to manage a full list of patients on their own. Experience of new graduates did not always match these expectations. Of concern was the ability to 'keep accurate patient records' and 'self-reflection and knowing when to seek help', where a small proportion of trainers experienced difficulties.

Conclusions: Trainers' expectation and experience in relation to non-clinical skills of a new graduate were investigated. Although they had high expectations, the majority reported only minor problems overall. There were a few areas where concern was raised.

Introduction

In England, Wales and Northern Ireland, there are 13 universities with dental schools offering undergraduate degrees in dentistry. The undergraduate degrees in the UK should prepare dental students to 'meet the outcomes required for registration' set by the General Dental Council (GDC); these learning outcomes are grouped into four domains: clinical, communication, professionalism, and management and leadership (1). European and international guidance is also available on the skills required upon graduation. The Association for Dental Education in Europe (ADEE) has published 'The Profile and Competences for the Graduating European Dentist' (2, 3), which provides guidance in the form of competences. The competences are organised into seven domains: (i) professionalism, (ii) interpersonal, communication and social skills, (iii) knowledge base, information and information literacy, (iv) clinical information gathering, (v) diagnosis and treatment planning, (vi)

therapy: establishing and maintaining oral health and (vii) prevention and health promotion. These can be readily mapped to the GDC domains for the UK dental graduates. In the USA and Canada, similar official documents, based around competencies, have been published to help in the accreditation process. The US document from the Association of Dental Education in America (ADEA) was revised in 2008 and has six domains: critical thinking; professionalism; communication and interpersonal skills; health promotion; practice management and informatics; and patient care (4). It is clear from all the available documents that professionalism and communication are viewed as essential skills.

As with all such documents, the learning outcomes and competences are broad based, requiring interpretation before implementation with inevitable variation between university degrees. On graduation, and to work within an National Health Service (NHS) general dental practice within the UK, a new graduate from a UK dental school must complete a one-year period of dental foundation training (DF; called vocational training in Scotland), which has been mandatory since 1993 (5). The DF programme is designed to further develop the skills of the new graduate and has its own curriculum document with similar domains to the GDC 'preparing for practice'. Prior to August 2013, this curriculum covered a 2-year period of DF training, which included the mandatory 1 year in primary care practice (6). Dental foundation training now refers to the 1 year of mandatory training and follows an interim curriculum (7). This structure facilitates the assessment of new graduate preparedness for general dental practice. In the UK, DF training programmes are quality managed by dental postgraduate deans/directors based on postgraduate deaneries that are regional in England and national in the other devolved countries. The continuity between dental schools and DF training is ill-defined and a cause for concern.

In recent years, dental schools in the UK have been under pressure to increase undergraduate numbers (8), and this has led to concern that the clinical experience offered to undergraduates has diminished and resulted in a new generation of graduates that is not as well prepared for clinical practice as their predecessors. Anecdotal feedback from DF trainers and others has suggested that this is due to their lack of clinical experience (9, 10). This is not new: the view that graduates were more prepared in the 'good old days' has been discussed over the last two decades (11, 12), and these sentiments are not solely limited to dentistry. In the medical literature, concerns have been voiced recently about medical students' preparedness for the workplace (13–15).

Clearly, anecdotal evidence is not a robust way of deciding whether there are flaws in the education of dental undergraduates. It is therefore important to collect more detailed information and identify, if possible, any shortcomings in new graduates' training. Such collected data can then be used to better inform discussions between DF trainers and dental schools and clarify the expectations of both undergraduate and DF tutors. The aim of data gathering and discussion should be to improve the new graduates' preparedness for the next stage in their training. Although this study was based in the UK, the skills required are similar worldwide, and so the expectations of employers of new graduates are likely to be similar and therefore transferable.

Aims and objectives

This study was designed to investigate DF trainers' expectations of a new dental graduate in relation to core skills and explore whether these expectations were being met. Any disparity found between the expectations and experiences could suggest an area that requires further investigation.

This article presents the findings related to non-clinical skills, those related in particular to communication and professionalism. Results concerned with clinical skills are reported elsewhere.

Materials and methods

Study design and data collection

Participants in this study were DF trainers in England and Northern Ireland. Scotland and the defence services were not included because of differences in approaches to DF training and assessment. Wales was not included as this work had been undertaken previously. Data were collected using an online questionnaire (Bristol Online Survey). The content was based on a postal questionnaire used in a preliminary study undertaken in Wales in 2010. Minor adjustments were made to some response options to enhance sensitivity and to improve the accuracy of answers. A small pilot was undertaken locally to assess ease of use and time required to complete the online questionnaire. Foundation training is structured into geographical deaneries headed by a postgraduate dean. All postgraduate deans/directors and DF advisors (often known as training programme directors) in England and Northern Ireland were contacted and informed about the study and their support was requested. Consent to take part was obtained from all 12 postgraduate deaneries. An invitation letter, information sheet and link to the online questionnaire were distributed via email to all deaneries, and this was forwarded locally to all DF trainers in the 2011 training programme ($n = 959$) towards the end of the DF training period. The completion of the survey was optional and responses were anonymous. To improve the response rate, blanket reminder emails were distributed at regular intervals using the local deanery support. Non-responders were unable to be followed up individually as anonymity had been assured to trainers to maximise the reliability and validity of responses.

Questions were designed to probe expectations and experiences of those non-clinical skills outlined in the dental undergraduate curriculum and in the dental foundation curriculum (1, 2, 16). Similar skills are expected in the European and USA statements (2, 4). The questionnaire was divided into three sections. Section 1 sought generic data relating to the trainer. Section 2 focussed on the trainers' general expectations of a new trainee. Trainers were initially asked whether they expected a trainee to be able to manage a full list of patients on graduation. Five response options were provided ranging from *on own with confidence* to *unable to undertake*. In the next questions, trainers were also asked to select the options, such as *always,*

TABLE 1. Eleven ability statements

Listen to a patient effectively and respond appropriately
Explain a treatment plan effectively to a patient /carer
Keep accurate patient records
Communicate bad news to a patient with sensitivity
Communicate well in written form to other healthcare professionals
Communicate and work well with other members of the team
Accurately self-assess and seek feedback to improve standard of care
Adopt an ethical to their work (by showing integrity, being aware of confidentiality and appreciating diversity and equality)
Put patients' interests first, through adopting a professional approach to their work
Demonstrate a professional approach to patient complaints
Describe the principles of consent knowledgeably

TABLE 2. Difficulty statements

Did not know when to seek help
Poor time management skills
Did not integrate well with team
Patient complaints about work/attitude, etc.
Did not take responsibility for patient care
Had excessive time off work

usually, *occasionally* or *never* in response to the statement '*In general I would expect a new trainee to…*' followed by 11 abilities (Table 1). In section 3, respondents were given the same series of statements based on their experience of their current trainee. Reponses to these questions allowed trainers' expectations to be compared with experience. A further question asked trainers to provide a *yes/no* answer to whether they had experienced any of six listed difficulties with their current trainee (Table 2). In addition, opportunity was given to respondents to add free-text comments about their current trainee.

Ethical approval

Ethical approval was obtained from Cardiff University, School of Postgraduate Medical and Dental Education Research Ethics Committee. The National Research Ethics (NRES) were sent information about the project. They classified the study as 'education evaluation, akin to service evaluation' and therefore advised that it did not require NHS REC review.

Analysis

All data were imported into SPSS v18 (SPSS Inc., Chicago, IL, USA), and descriptive analysis was undertaken.

Results

Of the 959 trainers, 510 (53.2%) completed questionnaires were returned with no missing data. Responses were received from all 11 deaneries in England and the one deanery in Northern Ireland. However, there was significant variation in the response from each deanery (Table 3).

Data were collected on the place of graduation of the trainers' current trainee. Trainees graduated from 15 different dental schools in the UK. Table 4 shows the distribution. The data included 40 trainees who had graduated from outside the UK.

TABLE 3. Response rate in relation to dental foundation deanery (n = 510)

Deanery	Number of trainers	Percentage of total	Deanery response rate%
Deanery 9	76	14.9	96.2
Deanery 4	33	6.5	66.0
Deanery 2	49	9.6	64.4
Deanery 3	88	17.3	64.2
Deanery 10	65	12.7	54.0
Deanery 7	16	3.1	48.4
Deanery 5	29	5.7	44.5
Deanery 12	26	5.1	42.6
Deanery 1	42	8.2	40.3
Deanery 6	31	6.1	39.2
Deanery 11	31	6.1	38.8
Deanery 8	24	4.7	28.4
Total	510	100.0	Total 53.2 Range 28–96

TABLE 4. Dental foundation trainees' dental school of graduation (n = 510)

Dental school	Number of trainees	Per cent
London – Kings College	96	18.8
London – Barts and the London	57	11.2
Sheffield	48	9.4
Liverpool	44	8.6
Bristol	43	8.4
Birmingham	41	8.0
Newcastle	38	7.5
Manchester	32	6.3
Leeds	29	5.7
Cardiff	17	3.3
Belfast (Queens)	13	2.5
Glasgow	5	1.0
Dundee	3	0.6
Aberdeen	1	0.2
Lancashire	1	0.2
Outside the UK	40	7.8
Unsure	2	0.4
Total	510	100.0

DF trainer information

Table 5 contains the information relating to the demographics of the DF trainer respondents. Almost all respondents were experienced, with most having been qualified for at least 11 years. Indeed, over 48% had been qualified for 21 years or longer, and a further 37% had been qualified for between 11 and 20 years.

To gauge respondents' experience as a trainer, we asked how many trainees they had trained in the last 10 years. The sample included some very experienced individuals who had trained ten or more in as many years (19%), as well as those less

TABLE 5. Demographics of respondents

Year since qualification	*n*	%
5 years or less	7	1.4
6–10 years	68	13.3
11–20 years	190	37.3
21 years or over	245	48.0
Number of trainees		
1–3 trainees	188	36.9
4–5 trainees	126	24.7
7–9 trainees	100	19.6
10 trainees or more	96	18.8
Joint trainer		
Yes	146	28.6
No	364	71.4

experienced (37%) who had only trained one to three in the same period. The results were spread across the response options indicating diversity of training experience in terms of numbers of trainees.

In some training environments, the trainer shares responsibility for the trainee with another trainer, and this was evident in twenty-nine per cent of responses.

General expectations

A general question about a trainee's ability to manage a full list of patients was asked to gauge trainers' expectations. The results (Fig. 1) suggested that almost half (n = 247) of respondents felt that a new graduate should be able to manage a full list of patients on their own (*with confidence* and *with limited confidence*). This provides a benchmark or a baseline to assess trainers' expectations of the preparedness of a new trainee.

Table 6 illustrates the range of expectations expressed by trainers. Although at aggregate level, 48.4% indicated they expected a new trainee to be able to perform '*on own with confidence or with limited confidence*', at deanery level, there was a great deal of variation (from 32% to 58%).

DF trainers' experience of difficulties with current trainee

A yes/no response was required to identify whether trainers had experienced any specific problems (outlined in Fig. 2)

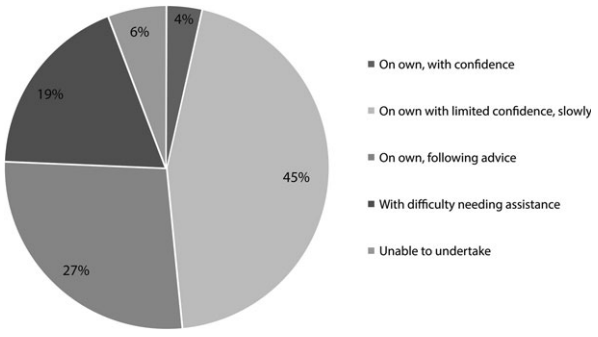

Fig. 1. On graduation, do you feel a dentist/trainee should be able to manage a full list of patients?

TABLE 6. On graduation, how do you feel a new trainee should be able to manage a full list of patients?

Deanery	On own with confidence or on own slowly % (*n*)	On own following advice % (*n*)	With difficulty, needing assistance % (*n*)	Unable to undertake % (*n*)
Deanery 10*	58.5 (38)	20.0 (13)	12.3 (8)	9.2 (6)
Deanery 3*	56.8 (50)	23.9 (21)	15.9 (14)	3.4 (3)
Deanery 9*	56.6 (23)	27.6 (21)	11.8 (9)	3.9 (3)
Deanery 8	50.0 (12)	29.2 (7)	16.7 (4)	4.2 (1)
Deanery 6	48.4 (15)	19.4 (6)	32.3 (10)	0.0 (0)
Deanery 4*	45.5 (15)	39.4 (13)	15.2 (5)	0.0 (0)
Deanery 1	42.9 (18)	33.3 (14)	19.0 (8)	4.8 (2)
Deanery 2*	40.8 (20)	32.7 (16)	18.4 (9)	8.2 (4)
Deanery 12	38.5 (10)	19.2 (5)	34.6 (9)	7.7 (2)
Deanery 7	37.5 (6)	25.0 (4)	31.3 (5)	6.3 (1)
Deanery 5	34.5 (10)	34.5 (10)	24.1 (7)	6.9 (2)
Deanery 11	32.3 (10)	29.0 (9)	22.6 (7)	16.1 (5)
Total	48.4% (247)	27.3% (139)	18.6% (95)	5.7% (29)
Range	32.3–58.5%	19.2–39.4%	11.8–34.6%	0–16.1%

*Deanery response rate >50%.

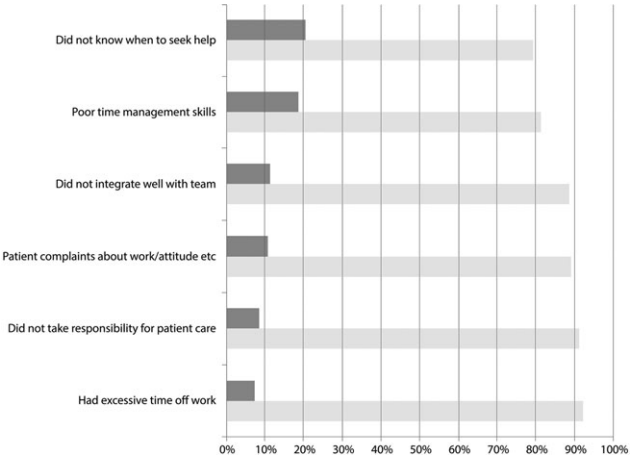

Fig. 2. Have you experienced any of the following difficulties with your current trainee?

with their current trainee. Of the trainers surveyed, 324 (63.5%) reported none of the six listed generic difficulties with their current trainee. The two difficulties reported most often related to trainees *not knowing when to seek help* (20.6%; n = 105) and having *poor time management skills* (18.6%; n = 95). A further 11.2% (n = 57) felt their trainee *did not integrate well with the other members of the dental team,* and 10.8% (n = 55) indicated difficulties related to *patient complaints about their trainee's work or attitude.* Low numbers were reported for *not taking responsibility for patient care* (8.6%; n = 44) and having *excessive time off work* (7.5%; n = 38).

Of the 186 trainers who had experienced difficulties, the majority reported that their trainee had experienced difficulty

in just one area (48% $n = 89$), and another 36% ($n = 67$) had a trainee who had experienced two or three difficulties. A minority 6% ($n = 30$) of trainers indicated that their trainee had experienced difficulty in four or more areas.

Trainers' expectations

Trainers' expectations of a trainee in relation to performing a series of abilities were measured using a 4-point scale (*always, usually, occasionally or never*). To help clarify the level of preparedness expected of a new trainee, the listed abilities were divided into four groups and colour-coded (shaded) based on trainers' expectations. These are presented in Table 7. The first group consists of the three abilities with high expectations that could be considered 'core' skills, as the vast majority of trainers (>78%) expect a trainee to *always* demonstrate them. The second skill group is based on 'upper middle' expectations where the majority of trainers have high expectations and clearly rate them as important (52–62%), but a significant percentage of trainers appear to realise that these skills are more challenging to a new graduate, so their expectations are lower than the aforementioned category. The lower middle group contains those skills where a relatively equal percentage of trainers selected *always* and *usually* (<10% difference), again suggesting that many trainers appreciate the need for more experience before being able to *always* achieve this skill. The *always* percentage for these skills was in the forties. The final two listed are skills where the trainers' expectations were lowest, where the expectation for *always* demonstrating these skills dropped to <40%.

Comparison of expectation and experience

In this section, we present the results of the trainers' general expectations and reported experience of their current trainee in relation to the eleven statements. To enable us to compare expectations with experience, trainers were required to evaluate their current trainee in relation to the listed abilities, using the same response options (*always, usually, occasionally or never*). Trainers' individual expectation was paired with their reported

TABLE 7. Dental foundation trainers' expectations – reported frequencies

		Expectation%			
Rank	Abilities	Always	Usually	Occasionally	Never
1	Adopt an ethical approach to their work (by showing integrity, being aware of confidentiality and appreciating diversity and equality)	79.6	18.8	1.4	0.2
2	Keep accurate patient records	78.8	19.6	1.4	0.2
3	Put patients' interests first, through adopting a professional approach to their work	78.6	20.4	0.8	0.2
4	Listen to a patient effectively and respond appropriately	61.8	36.7	1.6	0.0
5	Demonstrate a professional approach to patient complaints	57.8	36.7	5.3	0.2
6	Describe the principles of consent knowledgeably	52.0	41.2	6.7	0.2
7	Communicate and work well with other members of the team	46.1	50.8	3.1	0.0
8	Explain a treatment plan effectively to a patient	44.7	50.4	4.9	0.0
9	Communicate well in written form to other healthcare professionals	43.3	50.2	6.1	0.4
10	Communicate bad news to a patient with sensitivity	38.2	49.4	12.0	0.4
11	Accurately self-assess and seek feedback to improve standard of care	33.1	55.1	11.4	0.4

TABLE 8. Dental foundation trainers' experience of current trainee (skills ordered high–low experience<expectation)

			Experience		
Rank	Abilities	Trainers' expectation rank	Experience < expectation%	Met expectation%	Exceeded expectation%
4	Listen to a patient effectively and respond appropriately	Upper middle	42	51	7
2	Keep accurate patient records	High	41	53	6
8	Explain a treatment plan effectively to a patient	Lower middle	35	54	11
10	Communicate bad news to a patient with sensitivity	Lower	29	55	16
3	Put patients' interests first, through adopting a professional approach to their work	High	28	66	6
11	Accurately self-assess and seek feedback to improve standard of care	Lower	27	51	22
9	Communicate well in written form to other healthcare professionals	Lower middle	26	58	16
6	Describe the principles of consent knowledgably	Upper middle	24	62	14
5	Demonstrate a professional approach to patient complaints	Upper middle	24	61	15
1	Adopt an ethical approach to their work (by showing integrity, being aware of confidentiality and appreciating diversity and equality)	High	22	70	8
7	Communicate and work well with other members of the team	Lower middle	21	59	20

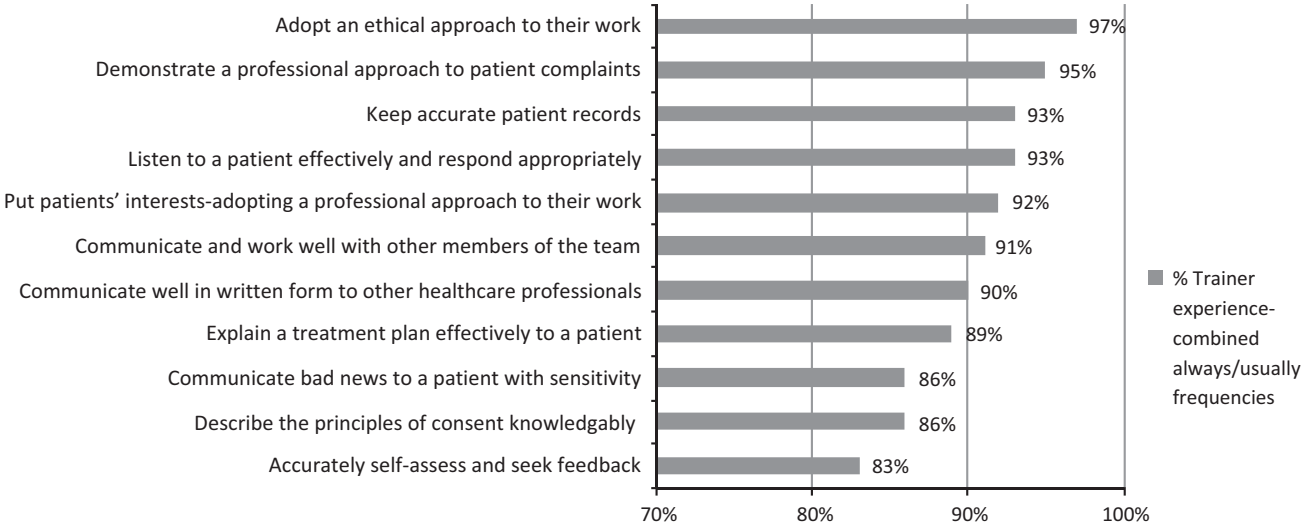

Fig. 3. Dental foundation trainees (%) able to always *or* usually *demonstrate the 11 abilities.*

experience. Table 8 shows for each item the proportion of trainers whose expectations were met or exceeded, or where trainee experience was lower than expectations (experience<expectation). Attention in the table is drawn specifically to experience<expectation, as the abilities are ranked in this order. When looking at all the listed abilities, trainers whose experience fell short of expectation ranged from 21% to 42%. For at least a third of trainers, experience fell short of expectations for the ability to *listen to a patient effectively and respond appropriately* [Rank 4](42%), to *keep accurate patient records* [Rank 2](41%) and to *explain a treatment plan effectively to a patient/carer* [Rank 8](35%). Expectations were met or exceeded for at least three quarters of trainers for *communicating and working well with the team* [Rank 7] (21%), *adopting an ethical approach* [Rank 1] (22%), *describing principles of consent* [Rank 6] (24%) and *adopting a professional approach to complaints* [Rank 5] (24%).

Figure 3 outlines the data in a different way by looking at the combined percentages of those trainees that were able to *always* or *usually* demonstrate the listed ability and complements Table 8. This table shows that the experience for self-reflection, describing principles of consent and communicating bad news, was lowest, with a higher percentage of trainees only able to achieve these occasionally or less.

Discussion

The overall response rate of the study was 53%, although this masks a large variation between deaneries. The highest response rate was achieved in Deanery 9 with 96% and the lowest in Deanery 8 with 28%. Clearly, the highest response rate allows us to be confident of the findings. Following collection and analysis of the data, tailored reports were returned to each deanery and dental school. Deanery 9 accepted a high number of trainees from one school. Therefore, the high response rate allowed us to provide a detailed report to both the deanery and that school. Where response rates were low, the data were much less robust, and so less detailed reports were provided to the deanery and associated schools.

The trainee's place of graduation was recorded, and as expected, the larger dental schools such as Kings College contributed to a greater proportion of the sample size. Most schools provided around 7–9% of graduates, with Leeds and Manchester providing a little less at around 6%. In this study, almost 8% of the trainees graduated outside the UK. Implementation in 2011 of a new central recruitment process in England and Wales (and Northern Ireland from 2012) may alter where a student undertakes their training, shifting from an historical pattern of many new dental graduates opting to undertake DF training locally near their school of graduation, to a more dispersed picture. This study preceded this change.

In the study, we asked the trainers to provide data about both their clinical experience and their experience of training new graduates. As expected, the vast majority of the trainers had been qualified for 11 years or more, demonstrating broad-based clinical experience much of which we would expect to have been in general dental practice. When looking at the number of graduates the respondents had trained, around a third reported that this was three or less suggesting some limits to experience here.

Current GDC guidance indicates that on graduation, a new dentist in the UK should work as part of a team with the suggestion that they are a 'safe beginner'. However, as recently as 2002, the GDC 'first 5 years' guidance on undergraduate training highlighted that on registration, a new graduate should be able to 'practice without supervision' (16). In the European profile and competences guidance (2) and in the US competences statement (4), it is clear that the expectation is for a new graduate to be able to perform unsupervised as an 'independent' practitioner. In the questionnaire, we reworded this as 'manage a full list of patients' on their own and asked trainers to comment on trainees' abilities in this respect. Forty-eight per cent of respondents believed this should still be the case for new graduates, although 45% felt that a new graduate would be

able to do so only slowly and with limited confidence. Looking more closely at this (Table 6), it is clear that there was significant variation between deaneries (32–58%), suggesting that the expectations in some areas of the UK are significantly higher than average. The implication is that expectations of some trainers are perhaps not in line with the current GDC guidance, and there appears to be a deanery influence on expectations. However, this expectation is broadly in line with European and US guidance. The question is whether this high expectation is reasonable and achievable. Debate on this issue has been seen recently in the British Dental Journal (9, 10).

A study by Wilkinson and Harris (2002), with medical interns (pre-registration) based in New Zealand, identified certain general and personal traits, which were commonly seen with borderline trainees (17), and they suggested that these traits were linked to their abilities to manage professional (clinical) tasks effectively. Trainers, in this study, were asked whether their trainee had had any problems related to these traits. Pleasingly, over 60% of trainers did not report any problems with their trainee. However, two problems were highlighted by a number of trainers: trainees who did not know when to seek help (21%) and poor time management (19%). The trainee who does not know when to seek help is a concern as it may suggest a lack of a patient-focussed attitude or an overconfidence, both of which could lead to clinical errors or difficulties. Indeed, such concerns were highlighted in the free comments such as '*…tendency to not seek advice when appropriate and continue into difficulties*', '*did not know when to seek help*', '*slightly over-confident, knows theory but needs to appreciate clinical competency weaknesses. Doesn't ask for enough help*' and '*tendency to over-confidence at the beginning of the year but a much greater awareness of limitations at the end*'. We discuss this further later in this article. Poor time management was also a concern, although the free comments suggested that this may include patient management issues rather than time-keeping issues (such as arriving late to work) which could be linked to inexperience and lack of confidence.

Detailed expectations of trainers in the area of professionalism and communication were examined and ranked. The higher the rank, the greater the proportion of trainers felt that this was a core skill. *Adopting an ethical approach to their work*, *keeping accurate patient records* and *putting patients' interests first, through adopting a professional approach to their work,* were all ranked highly (Table 6). Surprisingly, being able to *accurately self-assess and seek appropriate feedback* had a low ranking, which contradicts the results from the previous question asked of the trainers. The GDC 'preparing for practice' document (1) states *'being able to judge one's own limitations and work within them is essential*' (p 6) to being ready for practice. This skill is also at the forefront of the definition given of a safe beginner, '*they will be able to assess their own capabilities and limitations, act within these boundaries and will know when to request support and advice*' (1). In the European guidance, '*recognising their own limitations*' (2) is a supporting competency within the professionalism domain [section 1.12], and in US guidance (4), this skill is also recognised within the professionalism domain [section 2.2]. One possible explanation for the relatively low level of trainers' expectations is that they may have been affected by previous poor experience with trainees. Some evidence for this is highlighted in the free comments, '*I have been exceptionally lucky with my VDP/FD. He is capable yet knows his limitations, this has not always been the case*', '*please note that my expectations have been tempered by over 10 years experience of VT training and my expectations are now lower than they were*'.

Table 7 presents the data on trainers' experience of professionalism and communication skills of their trainee. It uses the shaded colour coding to show the ranking of the expectations and to highlight where experiences were lower than expectation. Three skills were identified as having the highest number of trainees failing to meet expectations. Given that one item – *Keep accurate patient records* – falls within those identified as 'core' skills, this is perhaps of most concern. The ability to keep accurate patient records is one that the new graduate might be expected to be able to do given the importance of this skill for patient management, but also for medico-legal reasons. This is reinforced in the current GDC guidance (1) '*…maintain accurate, contemporaneous and comprehensive patient records in accordance with legal and statutory requirements*' (p 18) and in the European guidance (2) '*producing and maintaining an accurate patient record and record patient treatment*' [section 1.14]. This is an area of concern and one that needs further investigation.

A high proportion (62%) of respondents expected trainees to *always listen to a patient effectively and respond appropriately*. Clearly, this skill is not just about listening: it is also about implicitly analysing and assimilating the information being gathered, asking appropriate further questions for clarification, before discussing either further clinical tests or clinical interventions to respond appropriately. This is a key skill but one that is likely to be developed with experience, over time extending beyond graduation, so it is perhaps no surprise that there are some difficulties in this area with the inexperienced DF trainees. Linked to this is the ability to explain a treatment plan effectively where a new graduate may struggle to simplify, but accurately explain the treatment requirements to the patient. Where the news to the patient is unexpected, then a new graduate may again struggle to explain bad news. As this was not highly ranked, it is clear that trainers understand the difficulties experienced by the new graduate in this area.

Putting the patients' interests first is fundamental to good practice and again is clearly highlighted by the GDC, European and US guidance. Trainers ranked this highly, but 28% of trainers found that their experiences were less than their expectations, raising some concern. Closer examination found that the majority of this change was only from *always* to *usually* which reduces some of this concern.

Reassuringly, a core skill that is central to professionalism and ethics was demonstrated by the majority of trainees. Seventy-eight per cent met or exceeded expectation by *adopting an ethical approach to their work* (*by showing integrity, being aware of confidentiality and appreciating diversity and equality*). As there were high expectations for this skill, the majority of the 22% who failed to meet expectations were able to demonstrate this skill *usually* (as opposed to *always*).

The skills of *self-reflection*, *describing principles of consent* and *communicating bad news* had lower expectations from trainers either because of previous experience of trainees or a realisation of the difficulties involved with these tasks. However, around 50% of respondents felt that this should *usually* (as compared

to *always*) be achieved for all three skills. Trainers' experience was that nearly 30% of trainees failed to reach this expectation with some only *occasionally* being able to do so. This may be a concern, and in terms of good governance and safe patient care, it is important that the new dentist knows their own limitations and when to seek help. Yet also, DF is a year of training and development, and writers have noted that carrying out activities 'just beyond one's current competence is necessary for the development of competence' (18). To learn and to enhance their skills, trainees will necessarily need to work outside their comfort zone and this is where the role of the trainer is vital in ensuring safe patient care. An overconfident trainee may engage in risky treatment well beyond their capabilities whilst an insufficiently confident trainee may be afraid to challenge and extend their capabilities. Ideally, trainees should know when to ask for help and when to use their own initiative. However, the trainee may feel restricted in asking for help depending on the dynamics of the trainee/trainer relationship. In interpreting these results, we need to be mindful that the DF year is a time of transition for the trainees – from student to dentist, from novice to a practitioner with growing experience.

Conclusion

The intention of this work was to produce results that could be used to inform discussion between DF trainers and dental school staff in an effort to clarify expectations and enhance the continuity between the undergraduate and foundation experience, for the benefit of the new dental graduate, their patients and trainers. What we do not yet know is the extent to which these results have been discussed locally. We are currently seeking to find this out. The results also have an international perspective as the skills discussed are broadly generic and required by all new graduates worldwide.

The expectation of trainers appeared high with nearly 50% expecting a new trainee to manage their own list of patients. Experience fell short of expectation across the abilities from 21% to 42%. However, much of the disparity between expectation and experience diminished when the *always* and *usually* options were combined and when it is realised that the difference was often between *occasionally* and *always*.

However, some areas of concern were noted, particularly in the areas of *self-assessment and seeking feedback* and *keeping accurate patient records*. Other areas were of less concern in the light of the trainees' inexperience. Clearly, some of these skills improve with experience and maturity, but others should be embedded on graduation.

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Conflict of interests

The authors have no conflict of interests to declare.

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