

is also a central factor contributing to high caries incidence.

This letter is aimed at highlighting the importance of obtaining a full social and dietary history for patients as many can develop work-related habits that can negatively impact their oral health. There is also a need to provide oral health education to members of the public within this field as many of them did not appreciate the detrimental effect of these common habits.

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Dental education

Medicine in dentistry

Sir, in a recent *BDJ* there was an intersection of ideas important for the education of dental graduates, such that they may safely practise dentistry. The letter from Tovani-Palone *et al.*¹ described the role of hospital dentists assisting medical colleagues in the care of patients during the COVID-19 pandemic and suggested greater integration of medical training at undergraduate level. In the same edition, Mather and colleagues analysed changes in learning outcomes for dental students between General Dental Council (GDC) curricula in 1997 (*The first five years* [TFFY]) and 2015 (*Preparing for practice* [PFP]).²

One element that has reduced significantly between the two curricula is the direction for teaching of human disease. In TFFY, previous guidance on teaching of medicine and surgery was significantly expanded, including that dental students were to attend medical and surgical clinics, and receive instruction in pharmacology and pathology. Curriculum sections, entitled 'Joint medical and dental teaching', 'Human disease' and 'General pathology and general microbiology' emphasised this new direction.

When the first edition of PFP was published, guidance for teaching undergraduates in medical topics had reduced to just a few lines: 'Identify general and systemic disease and explain

their relevance to oral health and their impact on clinical treatment' and 'Obtain, record, and interpret a comprehensive and contemporaneous patient history'. Perhaps the GDC meant this to also include a medical history. Mentions of funding had disappeared.

The UK has an ageing population with multimorbidity becoming common,³ and an increasingly dentate population,⁴ who will seek treatment from dentists who need to know how to safely care for patients with multiple chronic diseases and many medications needed for their management. The increasing medical complexity of our patients should be borne in mind by the GDC for future curricula, and by dental schools who need to prepare dental graduates appropriately.

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Paediatric dentistry

Parental responsibility

Sir, we read with interest the recent article published in the *BDJ* on parental responsibility (PR) which very clearly described the legal categories by which an individual may have PR for a child.¹ We were grateful for the acknowledgement of the 'Parental Responsibility Form' (PRF) that we developed and implemented at Liverpool University Dental Hospital and Alder Hey Children's Hospital. We have, anecdotally and through audit, found the form to have improved documentation surrounding the consent process for children. It is our hope that the form could be adapted and modified for use at other NHS trusts and at dental practices, as has happened in the case we respond to.

As noted in the article, guidelines in this area are 'ever evolving' and, as such, we wish to highlight where the PRF may be simplified. Category C refers to England,

Wales and Northern Ireland and the dates as to when a father is registered on the birth certificate (before 01/12/2003 and 15/04/2002 respectively) which are no longer needed. Any person born before these dates will now be 18 years or older.

The PRF does not cover every scenario. Further categories noted in our development of the PRF include how the Human Fertilisation and Embryology Act 2008 governs who is the legal parent of a child and who may then have PR. For example, if donor sperm is used at a licensed UK fertility clinic, a non-biological father who has consented to fertility treatment alongside the birth mother can be registered on the birth certificate and will then have PR. Another example would be if the birth mother and female partner are married or in a civil partnership at the time of the birth and the child was conceived via artificial insemination on or after 06/04/2009, then the female partner can be registered on the birth certificate and will then have PR. If the female partner is not married or in a civil partnership with the birth mother and consents to be the second legal parent at a licensed UK fertility clinic, then they too can be registered on the birth certificate and will then have PR.

Other scenarios we noted include whereby a parent/carer may not have PR but the child is not known to a local authority; for example, if a child lives with grandparents or the person with PR is deceased. These circumstances may require detailed discussion with the carers and advice to be sought from legal/safeguarding teams and dental indemnity organisations. A local authority may also share PR with the parent/carer. Without a court order, a foster carer will not have PR for a fostered child; however, a local authority may delegate authority to the foster carer to make certain decisions about simple aspects of dental treatment.

This highlights the difficulties of PR for children, and we wish to thank the authors for bringing this topic to readers' attention.

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