COMMENT

Letters to the editor

Send your letters to the Editor, *British Dental Journal*, 64 Wimpole Street, London, W1G 8YS. Email bdj@bda.org.
Priority will be given to letters less than 500 words long. Authors must sign the letter, which may be edited for reasons of space.

Dental education

Lack of evaluation tools

Sir, one weakness I have identified with the DFT curriculum is the lack of evaluation tools. Curriculum evaluation plays a vital role in facilitating educational development.[1] Currently, only trainees are required to complete an evaluation, in the form of a national survey. Surprisingly, there does not seem to be a formal method of collating feedback from educational supervisors, who as teachers play a significant role in trainee learning and development. Surely their feedback on aspects of the curriculum such as content, assessment processes and teaching strategies would be of value?

The survey consists of questions concerning an individual's training including supervision and the training environment, as well as more specific questions relating to their programme and assessments. It is fairly detailed and participants are given the opportunity to add comments. Data from the survey are collected and a report is produced, which summarises key findings. However, the last report was published in 2016 and although compulsory, received an overall response rate of 71%.[2]

To improve this aspect of the curriculum, I would incorporate several other methods of evaluation such as conducting informal small group interviews with trainees at the midpoint and end of the training period. The aim of this would be to gain a greater insight into the nature of the curriculum. I would also suggest direct observation of the curriculum in action, such as study days and teaching sessions conducted by the educational supervisor. Through observation, one can learn how not just the planned objectives are taught, but also the unplanned ones! Finally, as alluded to earlier, trainers should also complete a survey at the end of each training period.

Another area to develop would be support for educational supervisors. Due to a busy work schedule, trainers may find it difficult to plan effective lessons, develop their teaching skills, and consolidate existing methods of guidance, coaching and mentoring. I suggest developing a support network where trainers can communicate with each other and appraise each other's lesson plans and teaching strategies. Although it is argued that teacher appraisal schemes aid in motivating teachers to perform better, some trainers may not agree, suggesting that the process could result in loss of confidence, self-esteem or even worse, employment. However, the appraisals process should be seen as an opportunity for professional development and to become better educators of tomorrow's dentists.

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2. The Advisory Board for Foundation Training in Dentistry (ABFTD) and the Joint Committee for Postgraduate Training in Dentistry (JCPTD). National Survey of Dental Foundation Training 2016 Summary Report. 2016. Available at: https://webcache.googleusercontent.com/search?q=cache:cJ5c1W0XRhAJ:https://www.rcseng.ac.uk/-/media/files/rcs/fds/faculty/2016-dft-summary-report-pdf.pdf+&cd=1&hl=en&ct=clnk&gl=uk (accessed 5 July 2019).

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Higher-level dental doctorates?

Sir, I recently attended the primary care academic conference in Leeds. While I was there, I enjoyed several well-considered, comprehensive presentations, but for me, a Magistra Litterarum level practitioner in epistemology, one thing stood out: it seems only higher-level academics understand the nature of knowledge.

My explorations suggest that research funded by the NHS does not support the justified-true-belief theory of knowledge but only truth.[1] This means that only those with higher degrees, who are expected to comprehend the limitations of their methodologies, are able to meet the NHS funding guidelines. I would be interested to know whether the dental community is aware of this shortcoming, and if there is scope for PhDs, lower doctorates, to also gain this understanding, so they can make greater contributions to dental investigation and a stronger, safer, more educated community. In doing so, the NHS and NIHR will enjoy greater value for money.

I wonder if there are members of the dental community with higher doctorate level qualifications, such as the D.Litt, D.D, ScD, MedScD, LLD who may be willing and able to help filter down this learning for the good of dentistry as a whole. Incidentally, my own thesis can only be marked by higher doctorates.[2] I am working to teach the basic principles of the nature of knowledge to my peers, through my LDCs – if you are interested in hearing more about my practice and research or you are a higher doctorate, do please get in touch (Debbie_2383@hotmail.co.uk).

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1. Chappell S G. *Plato on Knowledge in the Theaetetus and Meno*. 2005.
2. Martin D. The case for understanding how healthcare professionals use knowledge. 2019. Under peer-review.

https://doi.org/10.1038/s41415-019-0684-x

Regulation

Bullying and harassment

Sir, I am writing to you in response to recent news articles online in the *BDJ* with regards to what is deemed 'serious' with regards to fitness to practise cases conducted by the General Dental Council (GDC),[1] and rising levels of bullying and harassment being reported by NHS staff in the recent 2018 NHS staff survey.[2]

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