“...has primary dental care yet emerged as a distinctive entity?”

Developing primary dental care

Healthy collaboration continues at the Royal College of Surgeons of England between the two Dental Faculties, the Faculty of Dental Surgery (FDS) and the Faculty of General Dental Practice (FGDP UK). This has led, for example, to the excellent new joint membership examination designed to assess completion of foundation training. Central to debate in recent years has been consultation with all FDS members and fellows, who are of course, mainly dental specialists. An important message emerged from this – that there is concern that a body of distinctive knowledge and evidence in primary dental care has yet to emerge to complement the undoubted knowledge base in the dental specialities.

A central question therefore is whether primary dental care has yet emerged as a distinctive entity characterised by a unique body of scientific knowledge applied in practice? Turning first to the scientific basis of primary dental care, this is certainly underdeveloped compared to primary medical care. For example, there are only two professors of primary dental care in the UK dental schools, whereas there are professors of general practice in almost all UK medical schools. Second, reflecting this perhaps, overlap between primary and secondary dental care is much less defined than it is in medicine. Surprisingly, there appears to be little interest on the part of primary dental care practitioners in developing the scientific foundations of their sphere of practice, though FGDP UK has developed research competencies and networks to increase research interest and is working hard to promote research activity in other ways.

Does this matter for dentistry and more importantly for patients? Of course it does. A very large proportion of dental graduates, much larger than the proportion of medical graduates, will practice in primary care. Although, as in medicine, many practitioners work in the community as specialists, most are generalists and it is crucial that their practice is underpinned by high quality evidence. The lack of this was apparent in the recent National Institute for Health and Clinical Excellence (NICE) appraisal of evidence relevant to the production of guidelines on recall intervals in dentistry. There are many disciplines relevant to primary dental care with which it has yet to collaborate in sustained, productive research, in social marketing, economics and business science for example. Some specialties of dentistry at the interface between primary and secondary care have of course already emerged, such as community dentistry and, more recently, special care dentistry, which are based on distinctive knowledge, experience and skills. But this still leaves the GDS and most of private sector dentistry with insecure foundations in universities

– the most important sources of reliable new evidence of effectiveness – compared to primary medical care.

To try to address this problem, the Clinical Academic Careers Panel (CACP) which makes funding decisions concerning applications for Academic Clinical Fellows (ACFs) and Clinical Lecturers (CLs) in medicine and dentistry identified academic primary dental care as a priority for development. CACP encouraged applications to develop training throughout academic dentistry and in this discipline and in restorative dentistry particularly. Many applications were forthcoming and most of UK dental schools are in the process of recruitment – but in contrast to primary medical care, there were almost no applicants from primary dental care and none at all for In-Practice Fellowships (IPF) from general dental practitioners.

Where are the solutions? The Dental Faculties of Royal Colleges can highlight the problem and do all we can to help solve it, but it is surely for primary dental care to take the lead. Unless dentistry wishes to undermine its traditional foundations in Russell Group, research-led universities, development in and with existing dental schools is the way forward. The medical model in which academic GPs maintain both practice and university bases seems applicable in dentistry.

A great deal has been achieved in academic primary care in the last 10 years. A White Paper was published in 1996, and the Mant Report and the Medical Research Council topic review were published in 1997. Research capacity and a personal awards scheme have been developed since. Equivalent steps are needed in dentistry, taking account of the particular needs of primary dental care. There is merit in developing a primary dental care group within the Society for Academic Primary Care (SAPC) to capitalise an expertise in medicine. It is surprising that this has not already occurred. Academic primary medical care emerged as an academic discipline as a result of the need to establish an evidence base – a need which was recognised by its pioneers in Cardiff, Edinburgh, London and Manchester. Concern about the way in which academics in secondary care used general practice as a laboratory was a further factor.

Above all, by strengthening the foundations of dentistry, developing the evidence base of primary dental care will drive up standards of treatment and prevention.

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