Dental education

Is Black Lives Matter over now?

Sir, I am a third-year dental student at Queen Mary's University London. As a student that is enthusiastic about dental education, I am constantly observing and reflecting on areas that require change. While the focus on the Black Lives Matter (BLM) movement has subsided, with fewer local demonstrations and reduced media coverage, it does not mean that my passion for equality has also diminished.

From my perspective, the problems in dentistry are two-fold. Firstly, the under-representation of black dental professionals within the workforce. Secondly, unconscious bias, where the consequences are evident in areas from dental education to the recognition of clinical manifestations of diseases, leading to delayed and missed diagnoses.

More role models will pave the way for future black dentists. But why is it that in 2014, when 3,410 prospective students applied to dentistry, of the 135 black students only 25 were accepted (19% acceptance rate)? This compares with 460 accepted Asian applicants (40.9%) and 549 accepted white applicants (54.1%).¹ These results highlight the risks of not separating the terms 'BAME' and 'black' in dentistry.

Under-representation consequently plays a part in clinical diagnosis. Low numbers of black academics and specialists limits the research, educational teaching and overall momentum on how skin colour affects the clinical manifestation of diseases.

Fortunately, I do believe change and adaptation is happening in dentistry. Medics are also taking a structured and academic approach, with a new handbook due out on the presentation of different skin diseases written by a medical student at St George's University London.² The oral mucosa is not exempt in this, with racial pigmentation being misdiagnosed and delayed recognition of herpes labialis and Kaposi's sarcoma.

Social media is helping communities to grow, such as 'Melanin Medics', 'Black Budding Dentists' and the African & Caribbean Dental Association (ACDA). These have united, encouraged and inspired young black dentists and potential dental school applicants.

In July 2020, I, along with five other black dental students were invited to meet with the GDC's Head of Education, Head of Research

and Head of Policy to discuss our views and concerns. This positive recognition with active listening and suggestions for improvement, felt like dentistry is finally reacting to the BLM movement.

BLM isn't over now, with changes occurring in our dental schools, the GDC, medical education and in our dental CPD. I ask of the GDPs up and down the UK, to reflect on their own impact within the dental community and consider engaging in verifiable online CPD webinars, discussions and articles investigating and bringing light to problems that exist with diversity and equality.

In order to sustain the momentum in striving for equality and the highest standard of care, we must commit to this form of life-long learning. I'm sure dental professionals will be eager to understand more about the specific problems that manifest from a group of under-represented individuals. Together with my peers, we shall continue to research and actively work on these barriers in dentistry, thus striving for equality.

T. Kadiyo, V. Mellish, London, UK

References

1. Gallagher JE, Calvert A, Niven V, Cabot L. Do high tuition fees make a difference? Characteristics of applicants to UK medical and dental schools before and after the introduction of high tuition fees in 2012. *Br Dent J* 2017; **222**: 181-190.
2. Rimmer A. Presenting clinical features on darker skin: five minutes with ... Malone Mukwende. *BMJ* 2020; **369**: m2578. doi: 10.1136/bmj.m2578.

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Diminished impact

Sir, we read the paper on dental core training with interest given the premise is important.¹ Understanding the motivation for undertaking non-compulsory training assists in programme development and ensures that it aligns with future career intentions. Unfortunately, the impact of this paper is diminished by the misreporting of the survey data.

Within the results section, the narrative contradicts the data presented within the figures. For example, Figures 4 and 5 graphically represent the survey responses, indicating that the majority felt the SJT was fair and realistic (78.7%) and 37.2% felt it beneficial to the application process. This is at odds with the authors' interpretation that '47.6% of respondents felt that the SJT was beneficial to the application and ranking process, only 9.3% felt it was fair, representable and realistic'. It is reassuring to

see the findings represented within the figures align with previously published data,^{2,3,4} including DCT specific research,⁵ which reported that 79.8% felt the SJT content fair and 84.2% considered it relevant. There is an implication in the paper that applicants do not regard the SJT as valuable and that 'the majority of the situations have never and would never arise'. It is important to highlight the robust national development process² with clinician and other stakeholder involvement throughout, which ensures the SJT content is relevant to the role.

Additional reporting or interpretation errors include how applicants' preference training posts were based on geography: Figure 9 implies 41.5% of applicants were prepared to accept a post in any location, while this is interpreted as 53.0%. This contrasts with only 4.4% reporting that they based their selection on the job description (Fig. 10; interpreted as 89.1%). It is perceived that this is linked to the 38.3% of trainees reporting inadequate teaching/learning experience (data from Fig. 12; though 39.4% is reported in the text) and could possibly explain the 39.3% intending to exit the programme. If applicants preference solely on location it is not surprising that they are less satisfied with the overall learning experience. While this is not expanded on within the discussion, it is an opportunity for continued programme review and improvement.

Overall, this paper highlights issues impacting on the quality of the DCT programme. Unfortunately, the misreporting of the survey data devalues the impact and leaves us questioning the conclusions drawn. Therefore, we raise concern that this paper will be accepted as a definitive exploration of a set of complex issues, which in its current format, is likely to mislead readers.

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The authors, Christopher C. Donnell and Jennifer I. Foley, respond: We thank Professor Patterson and her colleagues for recognising the importance of our recent research into the motivation, perception and experience of recently-qualified graduates in the pursuit of dental core training. As we would all concur, recruitment to educational opportunities should be robust, transparent and fair with an evidence-based approach to the selection process.

We can confirm that an error was introduced to Figures 4–15 by the publisher. We note that the print version of the journal reversed the Likert scale on the y-axis of these figures. Fortunately, this detail was picked up timeously and corrected on the online version which correlates with the prose within the results and discussion. As such, based on these corrected figures and as published online, we stand by our conclusions in this study.

Editor's note: the correction relating to this error can be found here: <https://www.nature.com/articles/s41415-020-2021-9>.

References

1. Donnell C C, Foley J I. Dental core training: the trainee perspective. *Br Dent J* 2020; **228**: 782–790.
2. Patterson F, Zibarras L D, Ashworth V. Situational judgement tests in medical education and training: Research, theory and practice: AMEE Guide No. 100. *Med Teach* 2016; **38**: 3–17.
3. Luschin-Ebengreuth M, Dimai H P, Ithaler D, Neges H M, Reibnegger G. Situational judgment test as an additional tool in a medical admission test: an observational investigation. *BMC Res Notes* 2015; **8**: 81.
4. Patterson F, Roberts C, Hanson M D *et al*. 2018 Ottawa consensus statement: Selection and recruitment to the healthcare professions. *Med Teach* 2018; **40**: 1091–1101.
5. Rowett E, Patterson F, Cousans F, Elley K. Using a situational judgement test for selection into dental core training: a preliminary analysis. *Br Dent J* 2017; **222**: 715. <https://doi.org/10.1038/s41415-020-2185-3>

Dental records

Photos please

Sir, photography can be used to accurately record the appearance of the oral cavity as well as following specific clinical conditions over time. With observance to current legislation,¹ photography can facilitate diagnosis, treatment planning and surgical procedures.^{1,2} It is also useful both as a medicolegal tool and treatment goal conformational record.³ Historically artists were used to produce illustrations from the descriptions of surgeons and physicians, which were highly influenced by their interpretation.

I carried out an audit to determine how often clinical photographs were present with a referral or taken at initial consultation in our department before biopsy of a suspected squamous cell or basal cell carcinoma. Photos were only present in 25% of cases, yet 85% of clinicians responded that they would have benefited from one. A diagram was present in 85% of cases, but this returns us to the same difficulty of subjectivity that was present in the late nineteenth century where the artist's illustration was influenced by the interpretation of the clinician.

In conclusion, clinical photos should become a standard part of the initial referral. Most referrers (GPs or GDPs) have access to a camera and with the implementation of e-referral systems across most UK Trusts, uncomplicated image acquisition and uploading should become standard. This is even more vital in this unprecedented time due to the risk posed by COVID-19 and will ultimately grant clinicians the ability to triage more effectively, improve patients' standard of care and prevent suspected cancer lesions being missed.

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References

1. UK Government. *Data protection*. 2020. Available at: <https://www.gov.uk/data-protection> (accessed April 2020).
2. Peres M. *The focal encyclopedia of photography*. 4th ed. Amsterdam: Elsevier, 2007.
3. Leathers R, Gowans R. Office-based management of dental alveolar trauma. *Atlas Oral Maxillofac Surg Clin North Am* 2013; **21**: 185–197. <https://doi.org/10.1038/s41415-020-2186-2>

Dental careers

Female career progression

Sir, you recently published an interesting research article regarding the career aspirations of female dental students and trainees.¹ It is well documented that there are increasing numbers of females entering the profession but this study further showed that more young female dentists are considering specialties that were traditionally male dominated. However, leadership positions are still disproportionately filled by males. This highlights the need for more female role models and mentors to be present in these positions. It is also important that dental institutions play an increasing role in educating their students regarding the career options available to them, including those that may allow them to continue working or continue specialty training pathways whilst affording them the flexibility that they may want.

The results from this study showed that 63% of respondents, of which 70% were females, wanted to work part-time 15 years post-qualification. This decision may play a role in hindering their progression to more senior roles. Therefore, there should be provisions in place to improve chances of career progression for those working part-time. The decisions regarding an individual's career flexibility are personal and

everyone is entitled to make these according to their own priorities. However, if their progression is being affected due to a lack of accommodation for those females who want to take career breaks or work part-time then, as a profession, we are failing 50.4% of our colleagues.

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Reference

1. Khan S, Ibrahim S, Butt R, Ahmed B, White D. The influence of gender on career aspirations of University of Birmingham dental students and junior trainees in the West Midlands. *Br Dent J* 2020; **228**: 933–937. <https://doi.org/10.1038/s41415-020-2187-1>

Oral health

Eponym confusion

Sir, many clinical signs and syndromes in medicine are named eponymously after the person who supposedly originally described them. In dentistry a common example is Sjögren syndrome.

These eponyms can be stated in the possessive, ie Sjögren's syndrome or non-possessive, ie Sjögren syndrome. Whilst this distinction may appear overly pedantic it does have importance and has been debated since the 1970s. Possessive eponyms have been argued as incorrect since the discoverers generally neither had nor owned the disorders, and having the two forms can generate confusion and problems with databases and literature searches.¹

The World Health Organisation actively discourages use of eponymous terms in medicine.² Furthermore, along with other bodies such as the American Medical Association and US National Institutes of Health, they specifically advocate that the possessive form is not used. However, there is no overall consensus, particularly among editors of medical journals where both forms continue. For example, in this journal's ten most recent papers mentioning the above example, seven state Sjögren's, two Sjögren and one uses both terms. Use of the possessive is now much less common in American than European journals.³

Therefore the current state of affairs is of mixed and arbitrary usage of possessive and non-possessive forms of eponyms throughout medicine. The main practical implication here, beyond being merely a technical point, is that literature searches using either form will yield different results.¹ Standardisation could solve this, however, is acknowledged