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.

Vocational training

DCT vacancies

Sir, I would like bring readers' attention to the numerous vacant dental core training (DCT) posts across the UK and the impact this is having on training and secondary care services. These posts are highly desirable for career development but are limited in number (around 700 across DCT1, 2 and 3). I was surprised that 61 posts lay vacant (September 2021), a vast majority of these within maxillofacial units. There may be several reasons for these vacancies.

Unfortunately, the pandemic has negatively affected oral and maxillofacial units, which comprise a majority of DCT posts. The reduction in face-to-face assessments and in operating time has led to reduced surgical experience for trainees, particularly at the height of the pandemic. DFTs may have had very limited dental experience during the pandemic, with the reduced ability to see patients due to AGPs and fallow periods, and re-deployment to other sectors. Some may wish to stay in general practice to gain further experience in general dentistry, which had been reduced due to the pandemic.

There has been a change in the shortlisting policy for application for a DCT post. Following the Situational Judgement Test (SJT), 282 candidates were not invited to interview, when in previous years all candidates were interviewed. Following post releases, Health Education England (HEE) had reduced the number of candidates in reserve which unfortunately has backfired. Posts lay vacant, which has increased the demand on existing staff but ultimately this is likely to affect waiting lists for patients. Interestingly, HEE has changed their policy for 2022 with all candidates who sit the SJT being asked to interview.

DCT has been a national recruitment process for several years. A high-ranking DCT will be more likely to receive a desired post while the reverse is true for candidates who rank less well. DCTs are advised to only rank posts they will consider accepting, but it is commonplace to rank all. By doing this, candidates who do not rank as well may still be offered a job. Candidates should be pushed on their commitment to a role and, ultimately, not enough committed candidates were interviewed leading to a shortfall.

Solutions for these issues are hard to address, but as someone who has gone through the DCT recruitment process, my experiences could help instigate change. We cannot change the impact of a global pandemic on healthcare but MDRS (medical and dental recruitment services) have now changed their policy on recruitment, which may be due to these significant shortfalls. More care and attention has to be taken to interview the right candidates who are willing to support the NHS at its time of need. One must wonder if this shortfall could have been prevented.

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Artificial intelligence

Do AI reports protect GDPs?

Sir, as a British dentist, maxillofacial radiologist and researcher since 1980 in artificial intelligence (AI) applied to dentistry, I was asked recently if AI-generated dental radiography reports protect general dentists from failure to diagnose litigation. Currently, 89% of general dentists report their own CBCT images.¹ Unless they have had special training, they are at risk of failing to diagnose oral and maxillofacial diseases, and vascular disease of the carotid arteries.

AI programmes are being designed to perform tasks normally carried out by human specialists such as medical and dental radiologists. As a peer reviewer for the journal *Oral Surgery Oral Medicine Oral Pathology Oral Radiology*, I see a lot of manuscripts from researchers who seek to publish their work in the field of AI and oral and maxillofacial radiology. The current state of the art is that some programmes are being used for the automatic generation of reports limited to caries, periodontal bone levels and endodontic treatment/apical radiolucencies from dental panoramic and CBCT images.

For an AI program to be equivalent to a dental radiologist, it must perform to an equal standard of diagnostic accuracy for the full range of expected pathologies, such as caries, the periodontal diseases, impacted teeth with proximity to the mandibular canal/maxillary sinuses, cysts of all types, benign and malignant tumours, infections such as osteomyelitis and sinusitis, bone dysplasias and degenerative diseases of the temporomandibular joints. In addition, vascular calcified atherosclerotic degenerative changes of the external and internal carotid arteries are often seen in panoramic and CBCT images much more frequently than malignant tumours.²

Randomised blinded clinical trials published in peer-reviewed journals are required to prove the accuracy and efficacy for reporting oral and maxillofacial diseases by AI programmes. To my knowledge, there are no AI programmes currently available which can perform these difficult diagnostic challenges equivalent to a dental radiologist. An AI report that says: 'This report was produced by an Artificial Intelligence program and then checked by a person' is not equivalent to a report produced by a GDC-registered dental