Footfall

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For just about as long as I can remember I have enjoyed watching, and from time to time visiting, the annual pageant that is the Wimbledon tennis championships. The combination of the unique Britishness of the event, the repeated, cyclical and seemingly never-ending analysis of the vagaries of this island's weather allowing matches to proceed or not and the ever-hoped for 'British' winner combine to make it a reassuring 'summer' hook in the calendar of the rolling year.

Apart from the tennis itself one thing in particular has always fascinated me. At the start of the tournament the grass is superbly green, uniform and lush. Two weeks later in spite of the microscopic care of the ground staff, parts of it have been worn through to a disfiguring scrub of brown earth. Not at all surprising of course but what a telling pattern it is; the exact usage pattern of the players. Almost no-wear along the doubles-court tram lines, very little on the bulk of the court itself but primarily where the most access is made according to where the greatest value lies for the athletes to gain advantage.

OPEN AND DIRECT

The clue is in the word 'access' and this is currently featuring a lot for the journal and the dental profession in terms of Open Access papers and Direct Access for patients to dental care professionals (DCPs).

As already heralded in an earlier editorial, the *BDJ* will soon offer the hybrid model of open access papers to researchers and authors.[1] This means that those papers 'blinded' as to their possible open access through the peer review process and then accepted on merit, will be published as *BDJ* content but available without restriction on the internet. We were delighted therefore to read the recommendations of the newly published Finch Group Report[2] set up in October 2011 to examine how UK-funded research findings can be made more accessible. The summary finding is that, 'Our view is that the UK should embrace the transition to open access, and accelerate the process in a measured way which promotes innovation but also what is most valuable in the research communications ecosystem,'; which both supports and reinforces the joint BDA and Nature Publishing Group decision to progress along this route.

The issue of Direct Access (DA) for patients to DCPs has generated a lot of correspondence, following on from an editorial at the start of the year[3] and given further impetus by a letter strongly opposing the idea.[4] The extended 'letters' section in this issue is in deference to the many emails we have received and represents the majority of the feelings expressed, being from various members of the dental team and all largely in favour of DA.

What is instructive is that the recurring theme in the published examples and of those received but not published, is one of the need for competence but the willingness to acquire this by various DCP group members. However, I am not entirely convinced that that is what the government, through their vehicle the Office of Fair Trading putting pressure on their own appointed General Dental Council to implement it, have in mind. More likely is the imperative to 'open up the dental market' to greater (supposed) competition, which in any event I frankly doubt is a realistic possibility.

Encouragingly, the collective message to emerge from these letters is the enthusiasm to join the debate, to be involved and to encourage the concept of the dental team with (perhaps ironically) greater referral patterns between dental professionals. It is far more likely that this will emerge as a successful and pragmatic way forward than a possibly more divisive wedge bludgeoned in under the banner of being best for the public and, collectively, our patients.

Rather as with the employment of dental therapists and hygienist-therapists now and with the deployment of 'old style' dental therapists from the New Cross School days, I suspect that changing disease patterns and consequential workforce arrangements (also market dependent) will have a far greater impact than DA ever will.

Overall, the clue to the success of both of these issues of access is how much they are used and valued, on the one hand by the scientific community and on the other by patients in the longer term for the benefit of oral health. What will the footfall tell us and what will the pattern of bare-earth scuff-marks be once, and if, these measures are implemented? We will be able to measure the open access papers easily at the journal but the utilisation or otherwise of DA to DCPs, while being more difficult to quantify may create the louder noise. Depending on what there is to report, we may revisit this next June as the Centre Court umpire again calls 'play' and the new grass tenses itself for the fray once more.

1. Hancocks S. Open (wide) access. *BDJ* 2012; **212:** 301.
2. Finch J. *Report of the Working Group on Expanding Access to Published Research Findings.* Available at http://www.researchinfonet.org/wp-content/uploads/2012/06/Finch-Group-report-executive-summary-FINAL-VERSION.pdf (last accessed July 2012).
3. Hancocks S. Direct line lack of assurance. *BDJ* 2012; **212:** 53.
4. Holden A. No to direct access. *BDJ* 2012; **212:** 355–356.

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