Dental academics

Our future dental academics

Sir, I am writing with concern with regards to the state of research funding for dental academics in the UK. Research from the Medical Research Council shows that the number of doctoral fellowships for dentists to be lowest across medics, allied health professionals, nurses and midwives, despite the number of pre-doctoral fellowships increasing five fold over eight years (2009–2017).¹ One has to ask why this is the case.

As a dental academic, I believe the root of the problem to be multifaceted. However, the key areas that require consideration are the lack of a well-established academic pathway and a general lack of research funding opportunities for dental doctoral fellowships.

Our medical colleagues have a plethora of potential sources of funding – charities, royal colleges, and national and international societies. However, the dental academic has a much smaller pool of funding from which to draw.

For a dentist, ultimately, the possibilities of receiving funding for a PhD fellowship fall frequently to the large research councils, where dentists are pitched against all healthcare professionals and medics. This has its own challenges as we are branded on-par with medics, who have a well-established successful academic pathway for trainees, including possible F1/F2 academic positions, meaning a better chance of getting meaningful research experience, publications and outcomes.

Academic DCT posts have only recently been introduced in dentistry, along with NIHR-funded ACF posts, but the pathways for dentists are often not well understood by the dental and research communities, preventing academics from reaching their full potential within the fellowship.

In addition, the possibilities for intercalated degrees within the dental undergraduate curriculum is limited compared to our medical colleagues, resulting in poorer uptake and as such, a lack of research experience at undergraduate level. In addition, with rising tuition fees and costs of living, the possibility of undertaking a PhD outside of a fellowship is an unrealistic option for many clinicians.

In addition to the lack of funding, it is difficult to impress the importance of oral health and its inextricable links to general and mental health when pitched against

research into more emotive themes such as degenerative diseases and vaccines, which are usually better understood by grant panels.

Compounding this issue is the lack of senior dental academics, with 66% of dental schools reporting difficulties in recruiting certain academic positions,² meaning fewer supervisors for research-keen students and staff at all levels. This lack of senior academics also weighs into poor provision of role models for young academics.

Going forward, I would urge research councils to look into and consider the challenges and barriers faced by the dental community in undertaking research. Stakeholders should be looking more closely at the medical academia models which are working far more successfully than our own pathways. We should also be encouraging young dentists to consider academia as a potential career to steer and instigate change for the future.

L. Whitehouse, by email

1. Medical Research Council. 2017 UK-Wide Survey of Clinical and Health Research Fellowships. 2017. Available at <https://mrc.ukri.org/publications/browse/clinical-and-health-research-fellowships-survey-2017/>. (accessed November 2018).
2. The Dental Schools Council. Survey of Dental Clinical Academic Staffing Levels 2017. 2017. Available at <http://www.dentalschoolscouncil.ac.uk/wp-content/uploads/2017/07/Survey-Dental-Clinical-Academic-Staffing-Levels-2017.pdf> (accessed November 2018).

DOI: 10.1038/sj.bdj.2019.143

Dental workforce

Dental workforce future

Sir, having completed one year of foundation training and now working as a core trainee in a district hospital, I have a good feel for what the dental workforce entails. Whilst at dental school, I was under the impression that one could simply work in the hospital service in a speciality/academic post or work in general practice as a GDP, specialist or DWSI.

I am writing this letter as I presume not everyone is aware of the changes that are due to occur. I certainly have not seen the changes documented anywhere in the literature aside from a poster/YouTube video online.

Whilst the above is still true, over the course of the past 12 months I have realised that the traditional workforce is changing. In October 2017, I was invited to attend 'The Future Of The Dental Workforce' – a workshop which brought together all members of the dental team, both clinical

and non-clinical, and members of the general public. I left the day feeling shocked at the plans the UK government has for the future of dentistry, to redesign dentistry from the ground up – educationally, clinically and at a service delivery level.

It is well-known that multiple financial restrictions have been put in place by the government for the dental workforce. These restrictions seem to have seeped through to academic institutions.

The University Of Liverpool has left the traditional five year BDS course and has redesigned it as a 'modular' course. This translates to the five year course having three exit points, at years 2, 3 and 5.

All students will start to learn the skills to become a dental hygienist with the option to leave at the two-year mark, or continue to study for an extra year and graduate as a therapist. Ultimately, after three years of studying, an additional two years have been put in place to give students the option to graduate as a dentist – a paradigm shift compared to the traditional and separate dental course available at universities.

The pattern that seems to be developing is that a new healthcare model is trying to be implemented and this was confirmed at the day's event in October 2017.

Dental hygienists, therapists and nurses are to be the mainstay of the future workforce, dentists will be working to triage patients who come in to clinic, delegating work as necessary to other members of the dental team.

At one point in the day there was mention of new polyclinics being developed. Further to the above clinical activity taking place, the polyclinics will house specialists in the clinical sub specialties. Additionally, a new speciality is looking at being created to help look after the elderly – gerodontology.

Hypothetically, one would think that the above model can provide an amicable balance between cost efficiency and delivery of high quality/appropriate care. Fewer general dentists, an increased number of auxiliary clinicians and a greater number of specialists seems to be what this new model revolves around. I don't believe the workforce has been well informed around the shift. General dental practitioners play one of the most important roles in day to day dentistry.

As a young dentist, I can already see how an ever increasing number of clinicians who finish foundation training end up in hospital