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).

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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

jobs. My understanding is that general practice was the traditional route that young clinicians stayed in.

Increased litigation, need for advanced skills/further education and greater job fulfilment seem to be the reasons why the new graduates of today stay out of general practice. One could argue that this fits in with the new healthcare model that is being planned by the office of the CDO. Is this healthcare initiative a great idea, a disaster waiting to happen, or a blueprint that will simply never leave the offices of the governmental elite?

A.S. Araghi, by email

Martin Woodrow, BDA Acting Chief Executive response –

The BDA sympathises with the issues raised in this letter about the Advancing Dental Care (ADC) project run by Health Education England. We have engaged with the project, raising concerns.

Our members can be assured that we will be opposing any moves that would devalue the UK dental degree. Our detailed views on the project can be seen on the BDA website.

We would note, for reassurance, that there was some confusion about the Liverpool dental degree during early HEE presentations; the information for 2019 entry suggests a full-time five-year BDS degree continues to be the course on offer. It is true, though, that some universities are moving to a more modular approach to teaching, something that we have questioned.

There are some aspects of the ADC project that could be positive, for example, more flexibility in postgraduate studies. Whilst the term ‘common entry’ (the pathway described in this letter) was taken out of the final phase one ADC report, ‘flexibility in undergraduate training’ is still a theme which may mean exactly the same thing. We also remain concerned about what will happen with dental foundation training. The BDA will continue to participate in the ADC process and make its views clear throughout this work.

Professors Callum Youngson (Dean of Institute of Clinical Sciences) and Vince Bissell (Dean of School of Dentistry) at the University of Liverpool response –

Thank you for the opportunity to respond on this matter and to correct some significant misconceptions concerning developments in Liverpool.

The School of Dentistry in Liverpool is engaged in a process of curriculum review that will result in the introduction of a BSc in Dental Therapy and revision of the BDS programme.

However, the BDS programme will continue to be a fully integrated five-year programme with a non-modular approach.

The revised BSc and BDS programmes will be separate with differing entry requirements. Students entering the BDS programme will do so with the expectation that, should they meet all the progression requirements along the way, they will graduate after five years with a BDS. In common with every other UK university

there will continue to be exit qualifications for students who fail to complete the whole programme, but there are no plans to allow an exit from either our BSc or BDS programmes with a qualification in Dental Hygiene.

The design of the programmes is such that the first three years of the BDS programme will be identical to that of the BSc programme, enabling students to be taught side by side, facilitating full realisation of the potential for developing the dental team and developing mutual respect. This is possible because of the very considerable overlap of learning outcomes between dentists and dental therapists in the GDC’s guidance document ‘Preparing for practice’.

This also raises the possibility that BDS students who are unable to progress on their programme, but who have fully satisfied the requirements for the award of a BSc in Dental Therapy, could graduate with that award. This would be considered an alternative award under specific circumstances.

There are already several graduate entry pathways in the UK where appropriately trained qualified students can apply for shortened BDS pathways (taking account of their previous learning - if it meets the needs of European requirements and ensures that all dental training takes five years).

BSc Dental Therapy graduates could therefore apply for entry to the BDS programme, involving a formal selection process and with due regard to the controlled status of numbers admitted to BDS programmes.

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