

# Compliance or Competence? Re-thinking Leadership Pathways in South African Dentistry

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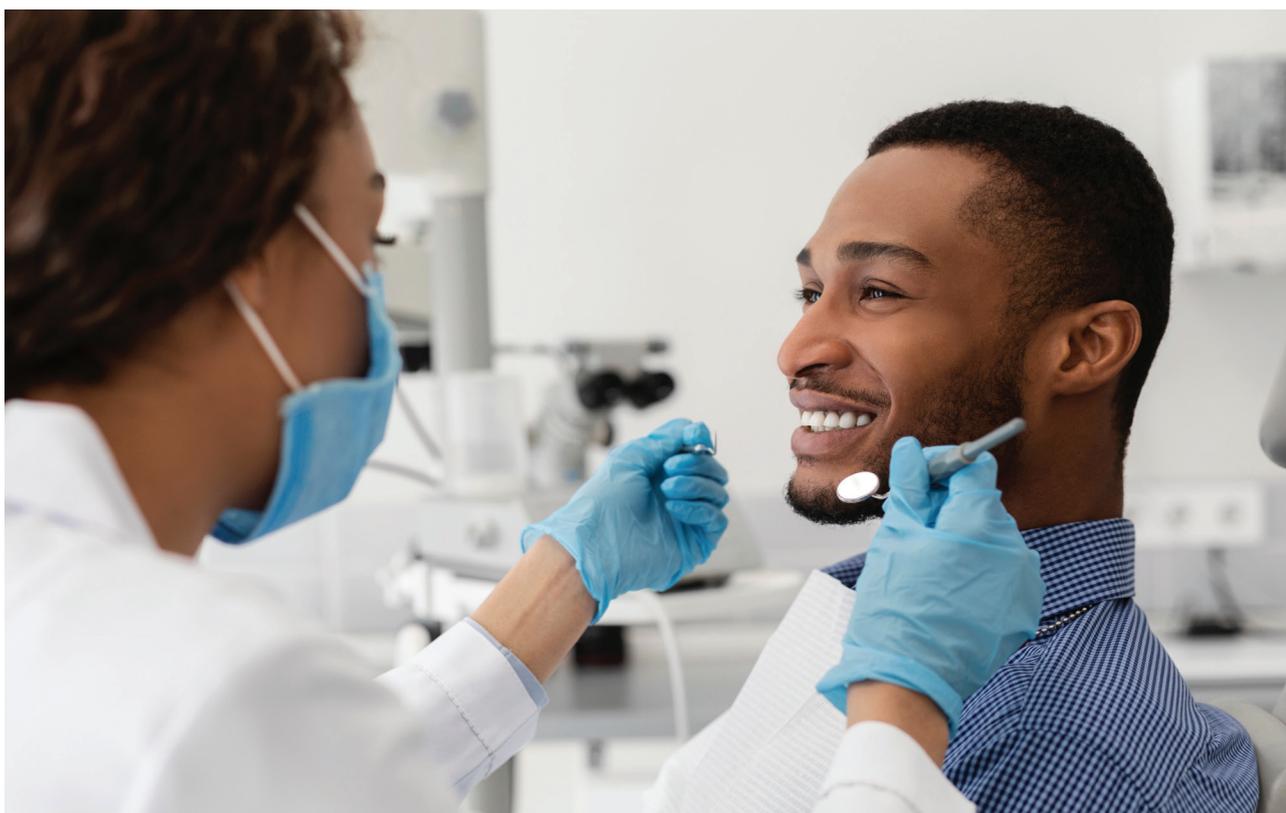
## INTRODUCTION

For South African dentistry, the challenges are well known: too few clinicians, persistent inequities in access, and fragile institutions. Added to this are the pressures of academic renewal and the shifting demands of regulatory reform. These forces are not unique to South Africa, but they are intensified by the country's socioeconomic realities and the strain on its health system. The more unsettling question, however, is whether the profession has the leadership it needs to respond. Leadership is not a peripheral concern: it is the capacity that determines whether oral health can adapt, innovate, and remain credible in the eyes of patients, students, and society at large.

Yet concerns are increasingly voiced that dentistry is experiencing a paucity of strong, credible leaders. The visible symptoms include shrinking senior academic ranks, high attrition of mid-level cadres, and uneven implementation of oral health programmes at district level, and even concerns with training programs. Beneath these symptoms lies a more uncomfortable question about the systems through which leaders are identified, prepared, and appointed.

Patterns of appointment and promotion sometimes reward compliance over competence, raising concerns about whether current systems reliably identify, utilise, and retain high-performing leaders. The question is: "are those most capable of shaping the future of the profession (whether clinicians, academics, or policymakers with demonstrable expertise and vision) side-lined, while less qualified or less prepared individuals are advanced into positions of influence and the spaces of decision-making?". The downstream effects are profound: misalignment between policy and practice, disengagement of talented professionals, and ultimately a dilution of the standards expected from teaching, training and a health profession that serves the public good.

Perhaps it is time for this profession to consider why dentistry in South Africa is struggling with leadership renewal, how our situation reflects broader systemic pressures, and what pathways might ensure that competence and integrity, not mere compliance, become the decisive factors in shaping the leaders of tomorrow.



### Why leadership matters in dentistry

Leadership in dentistry must be understood broadly and substantively, not reduced to holding titles or accumulating peripheral committee memberships. Effective leadership is multi-dimensional, encompassing clinical, academic, and policy/management spheres, each with distinct competencies and responsibilities, the latter being often neglected from CV-building activities.

Clinical leadership requires more than technical proficiency. It involves setting standards of care, modelling ethical practice, and creating environments where patient safety and quality improvement are actively pursued. In resource-constrained systems, clinical leaders must also make complex decisions about allocation, innovation, and service design, while also ensuring support and upliftment of those they lead.

### Academic leadership can be viewed as three interdependent domains:

- a. Educational leadership: sustained measurable self-improvement in health-sciences education with meaningful contributions to curriculum design, delivery, and evaluation; building true teaching portfolios that demonstrate reflective practice and continuous professional development; and mentoring the next generation of clinicians and educators.
- b. Research leadership: establishing a sustained, independent research portfolio that demonstrates intellectual independence, originality, and the capacity to attract funding and collaboration. Importantly, leadership is not about isolated publications but about building a coherent body of work that influences policy, practice, or pedagogy and contributes meaningfully to the knowledge frontier. This opens the proverbial can of worms where “leaders” may demand their names on publications, and have a faux-active research component on a CV that still lacks demonstrable independent original-research capacity, but this is an issue for another editorial.
- c. Institutional contribution: serving on and often chairing committees that matter for governance such as senate, faculty boards, ethics committees, professional councils, are often required as proof of leadership, rather than peripheral or “CV-padding” activities. However, dormant occupation of positions on committees has no reflection in evidence of contribution to these important activities. Nonetheless, leadership is evidenced by influence where informed strategic decisions about education and health systems are made.
- d. Policy and management leadership demands the ability to translate professional expertise into governance impact: influencing regulatory frameworks, designing and implementing oral health programmes, and aligning dental services with broader health system goals. This must be evidence-based and grounded in best-practice. This level of leadership requires sustained engagement with organisations of consequence, whether within government, regulatory bodies such as the HPCSA, or national and provincial health departments. Progressive or regressive, there is currently no feedback-loop to hold those accountable on these key performance areas. There is the potential for systems strain to occur, especially if the guidance received is “because I said so”.

Taken together, these elements begin to define a credible leadership profile: grounded in professional development,

demonstrable competence in teaching and research, and meaningful participation in decision-making structures that shape the trajectory of the profession. By contrast, advancement based on compliance or superficial CV-building undermines the profession, leaving dentistry without the leaders it deserves.

### The South African context: pressures on the leadership pipeline

Claims of leadership scarcity in South African dentistry cannot be explained away as a mere lack of qualified people. On the contrary, there are many clinicians and academics with established teaching portfolios, sustained independent research contributions, and even years of institutional service who are fully prepared to assume senior roles. Perhaps the difficulty lies in determining why and how these individuals are overlooked. Has dentistry rewarded competence and ability, or did it reward compliance?

Across dental schools, senior academic ranks were thin, with recent pressures to deliver academic promotions from all schools. Where once professors and senior lecturers provided mentorship and intellectual direction, the decline in these posts has the potential for pressure to fill leadership gaps quickly. In this scenario, selection processes could possibly elevate individuals without established teaching portfolios, without evidence of original and independent research leadership, and without experience of sustained progressive institutional service. The risk is obvious: when senior roles are awarded on grounds other than demonstrated academic and clinical leadership, credibility is weakened within the profession and in the eyes of students who look for authentic models of excellence.

In the public service, dental therapists and dentists with long-standing experience in patient care could find themselves passed over for managerial or programme leadership roles when preference might be given to high-visibility individuals whose public profile outweighs their record of service or policy implementation. While visibility can raise awareness of oral health, it cannot substitute for the managerial and governance competencies needed to sustain programmes at scale. The result is that seasoned professionals, those most able to bridge clinical realities with system priorities, are left without a voice at the leadership table and are forced to enact instructions they may disagree with, and to the detriment of the big picture.

The same pattern emerges in oral health programme management. Policy initiatives, such as school-based oral health, falter not because expertise is lacking in the profession, but because decision-making authority is too often concentrated in hands untested in educational delivery, programme design, or system-level research. The consequence is uneven implementation, reduced accountability, and a sense of frustration among those whose professional training and experience are sidelined.

South African dentistry thus finds itself in a paradoxical position: the problem is not an absence of competence, but rather the risk that competence is not consistently the decisive factor in leadership advancement. This raises a disquieting but essential question for the profession: if qualified, credible leaders are present but remain overlooked, why do our systems allow the advancement of those less prepared for the demands of leadership?

### The appointment question: merit, governance, and system risks

If the profession is not short of competent individuals, why is it possible for key leadership roles to end up occupied by those whose qualifications and portfolios do not meet the expected benchmarks? The answer may lie less in dentistry itself than in the broader patterns of public-sector governance in South Africa.

The Public Service Commission has repeatedly highlighted irregularities in recruitment and promotion processes across national and provincial departments. These include bypassing competitive advertising, constituting selection panels improperly, and overlooking candidates who clearly meet the requirements of posts. Such practices erode confidence in the system and generate environments in which compliance, loyalty, or visibility may matter more than documented competence. Dentistry, as a health profession nested within this broader governance ecosystem, cannot consider itself immune from these risks.

The Ministerial Task Team that investigated the Health Professions Council of South Africa (HPCSA) in 2015 reported serious governance lapses, irregular expenditure, and administrative dysfunction. While reforms have since been attempted, the episode exposed how easily a regulator can drift away from its professional mandate when governance is weak. Because the HPCSA directly oversees the registration, scopes, and professional advancement of all oral health practitioners, instability or inconsistency at this level inevitably weakens confidence in leadership pathways within dentistry.

The Health Ombud has documented recurring failures of accountability in public hospitals, pointing to a culture where poor performance is rarely sanctioned and excellence often goes unrewarded. This dilutes morale and disincentivises high performers from pursuing leadership tracks. In such

environments, those with strong academic or clinical credentials can find themselves stalled, while others advance through non-merit channels.

The result is a profession caught in a paradox: highly qualified academics and clinicians wait in line, while those with limited teaching experience, thin or non-existent research portfolios, and little exposure to consequential institutional governance are advanced into senior positions. The downstream effect is not only weakened institutional credibility but also a subtle redefinition of what leadership means.

The lesson here is that dentistry's leadership challenges cannot be separated from the governance systems in which it is embedded. The question for the profession, then, is not only how to prepare competent leaders, but also how to ensure that appointment processes consistently recognise and reward that competence rather than bypass it.

Global parallels: dentistry's leadership challenge is not unique. The governance dynamics shaping leadership in South African dentistry may appear stark, but they resonate with challenges observed across the world. International evidence demonstrates that dentistry, as a profession, often struggles to sustain robust leadership pipelines though the drivers differ from country to country.

In the United States, the American Dental Education Association (ADEA) has consistently reported difficulty recruiting and retaining senior faculty. Salaries that lag behind private practice earnings, coupled with heavy teaching and research expectations, have left many schools with thin senior ranks. The result is a leadership gap that mirrors South Africa's academic pipeline strain: fewer professors, fewer mentors, and weaker succession planning for deanships and department heads. In the United Kingdom, similar patterns have been described, with vacancies in senior academic posts creating instability in dental education.



A systematic review of leadership in dental practice concluded that research on the topic is fragmented, with inconsistent conceptualisation and limited empirical evaluation of training programmes. Leadership, in other words, has not historically been a core scholarly focus in dentistry. This lack of a strong evidence base makes it easier for superficial markers of leadership, visibility, personality, profile, to displace the deeper competencies of research independence, teaching excellence, and managerial governance.

In the UK and other high-income countries, service leadership has been undermined by broader workforce crises. Maldistribution between urban and rural areas, together with declining morale in public-sector dentistry, has made leadership roles difficult to fill with experienced clinicians. This, again, creates an environment in which visibility and availability, rather than competence, can become decisive factors in appointments.

Recent systematic reviews highlight the high prevalence of burnout among dental professionals worldwide, intensified by the COVID-19 pandemic. Burnout reduces willingness to assume leadership responsibilities and contributes to attrition from academia and public service. Even highly competent individuals with strong academic and clinical portfolios may choose to step back from leadership pathways when the personal and professional costs feel unsustainable.

South Africa's context, therefore, reflects both universal and particular elements. Like colleagues abroad, our profession is navigating faculty shortages, uneven leadership preparation, and the corrosive effects of burnout. Yet our situation is compounded by systemic governance weaknesses, irregular appointments, accountability deficits, and regulatory fragility, that magnify the risk of leadership misalignment. The global parallels provide reassurance that dentistry is not alone, but they also sharpen the imperative: if others are struggling despite stronger governance frameworks, then South Africa has even more reason to strengthen the merit-based identification, development, and appointment of its future leaders.

### Consequences of misaligned appointments

When leadership appointments are not grounded in demonstrable competence, the consequences extend far beyond individual careers. They shape the culture, credibility, and sustainability of the profession. Dentistry, as a discipline that sits at the intersection of clinical care, education, and policy, is especially vulnerable to the distortions that arise when titles are awarded without the requisite teaching, research, or managerial experience.

#### a. Erosion of academic standards

- When senior academic posts are filled by individuals without substantive teaching portfolios or a record of sustained, independent research, the result is a weakening of mentorship and academic credibility. Students and junior staff, who depend on leaders to model excellence, may perceive a lowering of standards, creating cynicism about the value of academic achievement. This could be more pronounced when instructions are issued that do not align to currently accepted norms, standards and evidence.

#### b. Fragmentation of service delivery

- In service environments, programme leadership placed in inexperienced hands often produces

variability in quality and accountability. Well-qualified practitioners who are overlooked for advancement may disengage, leaving essential services without the benefit of their expertise. The cumulative effect is fragmentation: uneven programme implementation, inconsistent patient outcomes, and an erosion of trust from the communities dentistry seeks to serve.

#### c. Morale and professional disengagement

- Perhaps the most corrosive consequence is the effect on morale. When high-performing individuals recognise that advancement is decoupled from competence, they either withdraw from leadership aspirations or seek opportunities outside of the public and academic sectors. Over time, this drains the system of its most credible leaders and reinforces the cycle in which visibility, compliance, or connections outweigh substance.

#### d. Institutional credibility

- Universities, hospitals, and regulatory bodies are judged by the calibre of their leadership. Appointing individuals without the academic or managerial credentials expected for senior roles diminishes institutional reputation, both domestically and internationally. For dental schools especially, credibility with accreditation bodies and professional councils depends on demonstrating that leadership is anchored in merit.

### Defining demonstrable competence

If dentistry is to align leadership with merit, then the profession must be clear about what constitutes "demonstrable competence." This cannot be reduced to holding a title, accumulating committee memberships, or gaining visibility in professional networks. Leadership credibility cannot rest on titles, visibility, or loyalty to networks; rather, competence in dental leadership rests on a portfolio of sustained achievements and contributions across four domains:

#### a. Teaching and Educational Leadership

- Documented contribution to curriculum design, delivery, and evaluation.
- A teaching portfolio that demonstrates reflective practice, peer evaluation, and student outcomes.
- Evidence of mentoring and developing junior colleagues.

#### b. Research and Scholarly Independence

- A coherent body of original research that demonstrates intellectual independence.
- Ability to attract funding, supervise postgraduate students, and contribute to advancing knowledge in dentistry or oral health sciences.
- A research profile that is sustained over time, not built on isolated outputs.

#### c. Institutional and Professional Governance

- Active and substantive involvement in decision-making bodies that matter: faculty boards, senates, ethics committees, or health policy advisory groups.
- Contributions that influence policy, accreditation, or governance processes beyond peripheral or "CV-padding" organisations.

#### d. Clinical and Service Leadership

- Setting standards of care, ensuring patient safety, and innovating in service delivery.
- Experience in managing teams, implementing programmes, and delivering outcomes in resource-constrained environments.

Taken together, these domains provide a transparent and testable framework for assessing competence. They move the discussion away from personality, visibility, or compliance, and instead foreground the qualities that sustain institutions, strengthen the profession, and serve the public good.

### Suggesting pathways to align leadership with competence

#### a. Transparent and competency based appointment frameworks

- Universities, hospitals, and provincial departments should adopt explicit criteria for senior appointments in dentistry, drawing directly on the domains outlined above. Appointment panels should require documented teaching portfolios, evidence of research independence, and governance contributions, not only clinical experience or public visibility.

#### b. Independent oversight in selection processes

- To protect integrity, appointment processes should include independent observers or external examiners, a common practice in global academia. This helps reduce the perception, or reality, of favouritism, or of having seats occupied by biased collaborators, and ensures that the profession holds itself accountable to its own standards.

#### c. Performance compacts tied to measurable outcomes

- Appointments to senior roles should be coupled with formal performance agreements that track outputs in teaching, research, service, and governance. This creates accountability and provides clarity about what leadership must deliver.

#### d. Building the leadership pipeline

- Competence at senior levels cannot emerge spontaneously. Leadership development must be embedded throughout the professional life course:
  - At undergraduate level, through early exposure to teamwork, communication, and leadership competencies.
  - At postgraduate level, through structured opportunities in curriculum leadership, research supervision, and service management.
  - At CPD level, through sustained professional development in leadership and management.

#### e. Supporting leaders to thrive

- No leadership system can succeed if leaders are chronically overburdened. Addressing burnout through protected time for research, mentorship, and professional development is not a luxury; it is the infrastructure upon which sustained leadership rests. Leaders must not only provide, but create opportunities to grow and develop others.

By defining demonstrable competence and insisting that it guide appointments, South African dentistry can resist the drift toward superficiality and compliance, and instead cultivate leaders who inspire confidence, advance knowledge, and strengthen the profession's service to society.

Leadership in dentistry is not an optional extra. It is the force that determines whether academic programmes retain credibility, whether clinical services remain sustainable, and whether policy reforms achieve their intended impact. South Africa is not without competent individuals; our institutions are full of clinicians, academics, and researchers with the portfolios, independence, and commitment required for

leadership. The concern is that systems of appointment and recognition do not always elevate them.

Patterns of appointment and promotion sometimes reward compliance or agreeability over competence, raising concerns about whether our current systems reliably identify and retain high-performing leaders. When leadership becomes decoupled from demonstrable achievement, the costs are borne not only by the profession but by patients, students, and communities who rely on dentistry's integrity.

In this piece I have suggested that competence can be defined in transparent, testable terms: through teaching portfolios, independent research leadership, governance contributions, and clinical service impact. The profession has the tools to measure and reward these achievements. What is needed is the collective will to insist that appointments at every level, from clinical units to dental schools to regulatory structures, are grounded in these criteria.

The uncomfortable but unavoidable reflection remains: if credible, qualified leaders are present but overlooked, why do our systems allow this? The answer is not to personalize blame, but to reform processes so that merit is visibly rewarded. For dentistry, the stakes are high: leadership choices today will shape the standards of our teaching, the quality of our services, and the credibility of our institutions for decades to come.

If South African dentistry is to thrive, we must have the courage to ask not only who is appointed but also on what grounds. Only then can we ensure that leadership reflects competence, inspires confidence, and secures the future of our profession.

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