# Public opinion

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**IN BRIEF**

- Describes how dental public health is becoming less well supported with regards to funding and by members of the dental profession.
- Highlights the lack of emphasis in the dental foundation training curriculum placed upon social determinants as a major cause of oral health inequalities.
- Proposes measures to improve recent graduates' appreciation for the social determinants of health.

OPINION

This opinion-based article aims to highlight the worrying decline in support for dental public health as a specialty. Not only is this specialty important for its role in commissioning services, it is crucial for the identification of vulnerable groups in society and ensuring dental services are acceptable and assessable for these populations. Dental public health also addresses the social determinants of health in its approach, acknowledging the impact of these in perpetuating inequalities and looking for multisectoral approaches to their management. This article also looks at the lack of appreciation for these determinants in dental foundation training and how a change in the structure of the programme could both address this and the current shortage of places.

I am lucky to still be able to meet up with colleagues from my foundation year; we all live fairly close and happen to practise in neighbouring areas so we try to gather at least once a week for a catch up and to swap stories. Even after six months of finishing our training, we have all started down different paths; a couple of the group feel that they already want to specialise in clinical disciplines and although the rest of us wouldn't choose that path ourselves, we can all respect each other's interests. That is of course, except mine; I like dental public health.

My friends and colleagues give me a strange look when I tell them this. A couple look at me with a sympathetic smile, 'Do you not like dentistry then?' they ask. The truth of the matter is, I love dentistry, there isn't too much not to like as far as I'm concerned. I get on with my patients and I enjoy treating those with high levels of anxiety. I also like the financial aspect of practice; I split my time between an NHS practice in Rotherham in a very deprived area, and a private practice in Barnsley. This split also gives me chance to meet and treat a wide variety of different patients with an even wider variety of needs .This is why my peers can't understand my desire to enter a specialty where gloves are entirely optional and it is populations being treated, not individuals.

This aversion that most dentists have to the discipline of dental public health is highlighted by the relatively few numbers of practitioners trained in the specialism. There is a general assumption that those who feel drawn to the specialty are technically inept and socially stunted, unable to deal with the realities and stresses of dental practice. The same derogatory view seems to exist for those community dentists who work within the salaried services; they couldn't cope with the rigours of practice and therefore earn less as a result. It seems such a shame that a misguided view would stop dentists either being interested in entering dental public health or community dentistry, or respecting the work that is done in these areas. Perhaps some of this prejudice comes from many general practitioners being ill-at-ease at the thought of treating some of these groups, through lack of confidence at meeting needs and managing difficult behaviour or challenging clinical situations.

So why dental public health? I have always been interested in sociology and psychology, as well as politics and philosophy. In fact, one of my tutors once asked me, 'Do you not think you should have done an arts degree?' Well I'm glad I didn't. Dentistry offers more than ample opportunity to indulge in these disciplines and dental public health is a specialty that offers a forum for all of these in a dental context and beyond. It wasn't too far into my foundation year, working in a deprived area, that I realised there was something stopping my patients improving their oral health that as a dentist I couldn't control. Their environment was not conducive to helping them improve their health as well as the other factors that contribute to oral (as well as general) wellbeing. In an area where unemployment and low income were rife, oral health and dental treatment were not seen as major concerns for my patients. When they had a problem or pain, that's what the dentist was for, not for six monthly check-ups or advice on toothbrushing. It is the wider social determinants of oral health which influence those from deprived groups more, that the speciality of dental public health looks at and aims to change, however this was not ever touched upon during my DF1 study days, in fact community dentistry, special care and dental public health were never spoken of while other specialties were championed. One of the major competencies of the foundation training curriculum in the clinical domain is health promotion and disease prevention.[1] While this competency is clearly held to be important and justifiably included, nothing is mentioned

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about developing an understanding in the importance of access to dental care for disadvantaged groups as well as demonstration of understanding of the social determinants of oral health.

Tudor-Hart showed that health professionals tend to congregate away from disease. He termed this the inverse care law.[2] This could be due to those that enter the dental profession tending to be from more advantaged social groups.[3] This may lead to difficulties in relating to patients from lower socio-economic groups, with professionals having less of an appreciation for those social determinants which influence health behaviours. Perhaps one way in which this can be countered is by the adoption of far more extensive undergraduate outreach programmes than are currently in place but also to use DF1 training to help newly qualified dentists gain more confidence in treating high needs groups. General dental practice may offer trainees some experience of this, however not all practices are placed in areas of high-need/low-access. In order to allow trainees more experience in this area, thereby helping to foster understanding of the challenges of treating such groups and hopefully encouraging trainees to carry on providing care to these groups after foundation training, more DF1 places could be created in dental access centres and salaried dental care settings. Dental access centres typically offer emergency dental treatment to those without a routine dentist or in out of hours situations. In undergraduate outreach programmes, this service may be extended to offer a full course of treatment before patients access routine care. Undergraduate outreach programmes both here in the UK[4] and abroad[5] show that such initiatives help to increase student confidence in treating vulnerable and high-needs groups. The introduction of more training places into these arenas may both address access issues in both the long- and short-term, help provide suitable training posts for those without places and perhaps most importantly help increase understanding of the social and environmental factors which greatly influence oral health.

The focus of public health dentistry is on these social determinants, recognising that the exercise of victim blaming that we can sometimes be led into just doesn't work in changing oral health behaviours. The illusion of choice is something many oral health practitioners just don't get; the factors in life as wealthy dentists that we wield free choice over may not actually be so easily chosen for those of low socio-economic status or those in cultural minorities. If I choose to smoke when my family and friends shun the practice that is my active choice; for someone who has never had any choice in the matter due to early exposure and being a member of a social group who sees smoking as the norm, the choice is less free. This is why pontificating about unhealthy behaviours and expecting to see change is so naive; if environment isn't considered then how can we even begin to comprehend the barriers in place for patients to overcome to achieve good oral health? The recent dental health surveys have shown a general increase in oral health.[6] This may lead the dental profession to rest upon their laurels to a certain degree. The fact is, while the general oral health of the population is rising, that of the most deprived is not.[7] This is leading to a greater gap between those with the best oral health and those with the worst. My interest in dental public health is multifaceted, but it is this disparity that interests me perhaps the most as to me, this situation seems unjust yet relatively ignored.

I hope that many readers would agree that tackling the inequalities in oral health is an important objective that needs careful planning and targeted strategies in order to be effective. Sometimes the work done by dental public health practitioners is not obvious to the general population of dental professionals because unlike placing a filling, the effects are often not immediate and not easily seen in individuals. Perhaps this is another reason why the specialty is not as popular as other disciplines within the profession. I also sense a degree of resentment whenever the topic of public health dentistry is brought up in conversation with other practitioners. It seems that there is a feeling that those specialists in dental public health reside in ivory towers and are out of touch and it is not acceptable for those in that situation to pontificate to hard-working GDPs the way to practise dentistry. To a certain degree I jest, but the point remains that there is a feeling that dental public health exists to complicate the lives of GDPs, instead of helping to facilitate that their services are directed at the right patient groups and supporting practices with non-clinical health promotion activities. The problem for general dental practice is that without a coherent plan to deliver effective dental care that reaches beyond just single practices, our ability to provide the best care to patients and communities is hindered.

At the present moment, I am studying for a master's degree in dental public health. Once I have finished this, I would like to at some point join a speciality training programme in dental public health. The worrying issue for me is that places to train and subsequent consultant posts are dwindling and in the coming reorganisation of the NHS and public health (which is to be nationally organised as Public Health England) any vacant posts may be lost and the funding for them reallocated. Not just because of my vested interest, but the loss of more dental public health posts would be worrying for the populations that would have been served by them. The British Dental Association (BDA) recognises this,[8] but support for the specialty needs to come from the whole dental community. Sometimes we can get caught up in believing our own hype, that everyone comes to see the dentist and that everyone does and should view teeth and gums with the same importance we do. We know that this just isn't the case, that there are sections of the population who do not access dental services. For some non-attendance is choice, however for others there are significant barriers in accessing services and it is the job of dental public health practitioners to identify these groups and organise acceptable and assessable services for them. Without the specialty in each locale and region, there will be those sections of the community who are subject to inequality that will not be identified and helped and those factors leading to inequalities will not be addressed. The fallacy that it is our efforts as dentists that lead to most improvement in oral health seems to perpetuate through generations of dental professionals; it is actually common across all of medicine that the effects of environmental and social change far outweigh advances in medicine and dentistry in improving population health.[9] This then suggests that the only way we can function effectively in improving oral health across all of society is actually to develop relationships with different sectors and industries

to deliver far-reaching health promotion. There needs to be a greater appreciation that dentistry is not just what happens in the surgery; perhaps changes in DF1 training can be used to facilitate this. Whatever one's view of the specialty is, love or indifference, I hope we can all agree that there is only so much good we can do treating individuals while ignoring the wider influences that affect oral health in society.


1. COPDEND. A Curriculum for UK Dental Foundation Programme Training. www.mjdf.org.uk/mjdf-examination/docs/gpt_curric.pdf (accessed 11 January 13).
2. Tudor Hart J. The inverse care law. *Lancet* 1971; **1:** 405–412.
3. Niven V, Cabot L B, Gallagher J E. Widening participation-a comparison of the characteristics of successful UK applicants to the five-year and four-year dental programmes in 2007 and 2008. *Br Dent J* 2013; **214:** 177–122.
4. Smith M, Lennon M, Robinson P. The Sheffield outreach teaching programme. *Br Dent J* 2010; **209:** 513–520.
5. McQuistan M, Kuthy R A, Qian F, Riniker-Pins K J, Heller K E. Dentists' treatment of underserved populations following participation in community-based clinical rotations as dental students. *J Public Health Dent* 2010; **70:** 276–284.
6. Steele J G, Treasure ET, O'Sullivan I, Morris J, Murray J J. Adult Dental Health Survey 2009: transformations in British oral health 1968–2009. *Br Dent J* 2012; **213:** 523–527.
7. Scottish Dental Epidemiology Coordinating Committee (SDECC). *Scotland's National Dental Inspection Programme, 2003.* 2004.
8. British Dental Association. D*ental Public Health Futures,* July 2011. www.bda.org/Images/dental_public_health_futures.pdf (Accessed 23 December 2012).
9. McKeown T. *The modern rise of population.* London: Edward Arnold, 1976.


# Erratum

## Editorial (*BDJ* 2013; **214:** 323)

*Consequences*

In paragraphs 2 and 3 it was suggested that the GDC only looked into the issue of direct access as a result of the OFT report, published in 2012. This is not correct.

The GDC's Direct Access Task and Finish Group was set up to look into this issue in 2011 and direct access was first discussed by Council in 2006.

We apologise for any confusion caused.