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After the first 125 years of the *BDJ* where might clinical dentistry be heading?

The obvious way to tackle such an inviting topic is to reel off a series of new products, materials and techniques that have been recently introduced to the world of dentistry or may be about to hit us with, as yet, unknown consequences.

We could explore the infinite possibilities of implant technology and its future development, including whether the price will ever come down to a sensible level; we could assess the chances of new restorative materials reaching the market that actually do what it says on the box and really work in the presence of saliva; we could start to imagine how the blossoming science of genetics and its widening influence will affect our view of healthcare and especially where it might lead dentistry. We might even wander into the area of infection control in an era where new viruses come along every ten minutes and antibiotics have failed to live up to the cure-all image they had in the latter half of the last century. We could do all of that – and more – but that, in my view, would be putting the cart very much before the horse.

Yes, the dental profession's collective obsession with all things technical could be allowed to prevail yet again, but not today. Given a milestone opportunity such as this, we should not allow ourselves to bask in the glory that our predecessors have created. We should not concentrate on those things we find the most comfort in. Yes, we should take justifiable pride in what has been achieved so far, but then we must turn our attention to the difficult task of deciding where we are heading tomorrow and for the next 125 years.

It seems to me that any discussion about the kind of clinical work we as a profession will be undertaking in the future revolves more around the direction of travel the profession itself takes over the next few years than the products and techniques that may flow from the work of our research colleagues. Researchers should always have one eye firmly fixed on the problems being tackled by the profession so that the work they do retains relevance to the worker beavering away at the enamel face.

The cathartic events of 1992 may have been politically damaging to the relationship between the Government in the shape of the NHS and the profession but they also wrought a change in the very fabric of the profession that will almost certainly never be reversed. History will show that 1992 was a wake-up call for the dental profession. How we react to that call over the next 50 years will write the next big chapter in our relatively brief history.

It was only in 1956 that the General Dental Council was formed and dentists ceased to be subject to the regulation of the General Medical Council. For the latter half of the last century the NHS has been the one and only significant influence determining how we in the dental profession behaved and what kind of treatment we provided for the patients we deal with.

The demise of a cottage industry

The cottage industry that was pre-World War II dentistry, then only 70 or 80 years into its history, was seismically shaken by the introduction of the NHS dental service in 1948. The need for massive amounts of work to be completed for millions of new patients led to a style of working that was alien to established dentists but was nevertheless welcome because of the massive injection of cash that accompanied it.

The eventual failure of that model of working comes as no surprise to many of us. There have been many voices sounding the alarm about the damage that NHS style provision was doing to our colleagues'

professional standards, not least the Tattersall Report as long ago as 1964. 1992 was indeed a watershed.

Many practitioners took the opportunity to 'jump ship' and found a new way of working that was more amenable to them and to a substantial cadre of patients who were willing to pay for it. But the dental profession is now staring into the abyss once more. The NHS is trying to find a new contracting approach to general practice dentistry as well as community dentistry, and is struggling to come to terms with twenty-first century dentistry itself. Equally, dentistry is struggling to come to terms with its new-found independence and perceived clinical freedoms. We are still passing through a period of dramatic change and times are indeed interesting. Sometimes it is difficult for people who are totally engrossed in the events of the hour to perceive just how much impact they are having and how events in turn are shaping their own lives.

Left alone to deal directly with patients, many dentists have discovered the pleasure of providing them with changes that improve their appearance and raise their personal self-esteem. The fact that this type of work is also seen to be more profitable fits in very comfortably with a group of professionals who have been encouraged for over 50 years to be ruthlessly efficient, to maximise output and to manage on minimal profit per item of treatment provided. This ingrained business-like attitude has been responsible for many young dentists being forced to shelve some of their moral and ethical standards, and before we go on to consider the dangers inherent in this way of working let us take this opportunity to remember who first placed on the profession the need to be ever quicker and ever cheaper.

It was the NHS. 'Pile it high and sell it cheap' may be an acceptable motto for supermarkets but in healthcare terms it is a philosophy of despair and always has been.

So, before I get started on the exciting prospects of what my successors might be doing in the average surgery in 2075 or even 2130, I think we have to address one or two very important and fundamental philosophical questions.

Reflection and evaluation are essential

There is no need to seek an apology if these questions prove to make for uncomfortable listening. One of our problems as a profession over the years has been our reluctance to look honestly into the mirror long enough and often enough to see what we are doing and what we have become. I hope my argument may persuade readers that audit is not just about the quality of radiographs, it should include an analysis of our individual and collective philosophical approach to what we do for a living.

If we turn up for work every day for 40 years and simply continue to do what we always did, we will have achieved very little. We may have packed a lot of amalgams and cemented a lot of bonded crowns, but as individuals we are unlikely to have moved on very far. Reflection and evaluation on past performance are an essential element of audit - whether it is on the incidence of dry sockets or why and how we devise treatment plans.

It would be too simplistic to say that every clinical decision taken should be taken totally free of external interference. None of us has ever had that luxury, nor will we. For example, I know that for a single tooth space these days an implant ought to be at least a candidate for the best possible solution. It is not. High cost and poor access to suitably trained practitioners militate against such a solution in my part of the world.

We all have to work within our existing envelope of clinical possibilities and the financial barriers that define our boundaries

I know that I can make a better job of rebuilding a patient's broken down mouth if I have a free hand to spend a great deal of money and infinite patience with which to persuade the patient to adopt a cleaner and healthier life style. Rarely do I have the money and even more rarely do I have the patience or the patient required.

I know that the child with carious '6s' at the age of six years needs considerable dietary advice and support over a lengthy period of time if an improvement is to be brought about. I know if the child comes from a certain postcode area with which I am familiar, the chances of success lie somewhere between nil and dreadful. I cannot afford to plough in the kind of effort that is required for no return either financial or clinical.

We all have to work within our existing envelope of clinical possibilities and the financial barriers that define our boundaries. Colleagues in hospital, university or community careers face precisely the same kind of limitations as those of us who operate in the alleged freedom and independence of general practice, the influences are not quite the same but they can be every bit as malign. The task we all face every day is that of maintaining the balance between the three interlocking factors that dominate our working lives. How can we keep unit cost down but at the same time keep quality up? If we manage to keep quality up, how can we keep quantity up? If we want

to raise quantity, how do we control total cost and maintain quality?

Our 'preventionist' colleagues have always believed that, ideally, patients should never need interventive treatment and should only ever require advice and encouragement to maintain a clean and healthy mouth. This is clearly wishful thinking but it should also serve as a highly desirable professional objective – shouldn't it?

If we are ever to conquer our twin scourges – caries and periodontal disease – it will probably be as a result of effective prevention and not as a result of intervention with an air rotor, no matter how clever. Trying to follow this philosophy with enthusiasm and working under current financial arrangements, I would be bankrupt in a couple of months. Not an attractive place to be.

I have always subscribed to the belief that the minimum possible level of clinical intervention is the most appropriate. The adult patient of the future is the child of today with less than one carious lesion on average. This minimalist approach is clearly not shared by colleagues whose impressive clinical photographs adorn some of our profession's lesser journals. High levels of destructive intervention appear to have been undertaken in mouths that were frankly only marginally less than perfect, in order to achieve the 'Hollywood smile' so beloved of the television camera and the glossy magazine close-up. By contrast the twenty-first century adult will be caries free or near enough and will present us with few of the complicated treatment conundrums that are familiar today.

Sadly predictable personal tragedies

It is accepted by most practitioners that complicated restorative work will always fail, eventually, and should only be undertaken when it is justified by a lack of feasible alternatives. Having been in practice for 36 years in the same town I have seen much of my carefully planned and executed work end up in the bin. Each time it is a personal tragedy but each time it was sadly predictable. As I see the children I dealt with many years ago deteriorating slowly into old age, I recognise the phenomenon that my dental public health colleagues have been warning me about for ages – the elderly dentate patient with multiple large restorations.

This group of patients is going to require a lot of attention between now and about 2040 by which time most of them will be gone and the younger and healthier adult group will hopefully predominate. A glance at the statistics for the over 100 year olds in the UK population over the next few years makes sobering reading when you consider that many of them will reach that age still equipped with their own teeth.

With a lot of effort, our growing evidence base assisted by our increasingly sophisticated Information Technology systems will provide us with a much better idea as to which treatments work best and under what conditions. If we are still floundering around in 2025 with paper records and filing cabinets full of cards we will have failed to grasp a significant opportunity to improve the quality of the outcome of the various treatments we offer our patients.

So after many years of thinking about it, I am left with a couple of simple questions I often ask myself about the dental profession. Are we merely businessmen and women, selling our precious time and expensive oral trinkets, with profit as our only motivation? Or are we genuine professional healthcare workers with suitable standards of behaviour underpinning our work and our approach to our patients and their health problems?

I would like to think that whilst we must always be able to make a good living in return for our lengthy training and lifetime commitment to further professional development, we would wish to remain committed to the role of the true healthcare worker as opposed to the pure businessman. The influence of the businessman in dentistry has been growing alarmingly and will have to be curbed if we are to retain the public's approval for what we do. The NHS has much to answer for in this respect and has driven their business model relentlessly, close to breaking point. Failure to convince the public that we are caring providers of healthcare will mean the end of our recognition as a distinct and separate professional group. We will have been demoted in their eyes to the level of a shopkeeper who sells white teeth.

The adult patient of the future is the child of today with less than one carious lesion on average

The second question that takes us on a little further than the first one, is the issue of cosmetic dentistry. In the last few years we appear to have moved on from merely repairing a carious lesion or its consequences by means of a material that is aesthetically pleasing in order not to damage the patient's life chances or self-image. A glance at the mouths of some of the people who were living in the Eastern bloc with their chrome crowns and base metal restorations is enough to put us off and I would never support any move towards that uncaringly pragmatic approach. For years I have been able to work alongside my orthodontic colleagues to establish a clean and healthy mouth for each of my young patients that is easy to maintain in that condition. For

those who had not taken the appropriate care and whose mouths had suffered as a result there was always the possibility of the repair work being done without any outward sign of that having taken place - the origins of cosmetic dentistry.

Things have now moved on to a very different scenario where perfectly capable, fully qualified professional staff are engaged in the dubious pastime of whitening perfectly healthy teeth in order to make the patient feel better about themselves. Let's be clear that I do the same thing so I am not criticising individuals, I am merely asking some very awkward questions about what we are doing and what we are achieving with our highly trained and expensive time.

So, what are we? Are we professional healthcare workers or are we now in the beauty trade? Should we be taking a dramatic vow of financial chastity?

So, what are we? Are we professional healthcare workers or are we now in the beauty trade? Should we be taking a dramatic vow of financial chastity? Should we ban all forms of cosmetic improvement to meet my arcane and unreasonable demands? How can we make sense out of these issues when faced with the real day-to-day pressures of making a living in the twenty-first century?

A profession split in two

These are provocative and challenging questions and the profession is going to have to answer them before we can say with any degree of certainty what our clinical working day will look like in 30 or 40 years time never mind 125. In my view the profession is destined to split into two distinct groups because of this impossible dilemma, one group serving the socially deprived patient group and one group serving the patients who can afford to buy the kind of smile we would all admire.

A dilemma is not just a problem writ large. A problem is normally capable of satisfactory resolution. A dilemma is not. Compromises are usually required to find a resolution of sorts and this dilemma in particular is incapable of resolution by all of us remaining true to any single philosophy. We are going to have to demonstrate considerable personal flexibility as patient demand changes and treatment patterns alter.

We know that the ravages of caries and periodontal disease still cause severe lasting damage to a significant section of the community in the UK. We also know that the majority of the patients so affected live in the poorer, deprived sector of the population, yet everything we seem to have been doing over the last 13 years appears to be turning our professional backs on the very people who need our trained professional help the most.

Privatisation of general dental practice is moving us back to where we were in treatment and availability terms before World War II – before the NHS – when only the reasonably off could afford dental treatment. In today's changed circumstances it could be said that high quality dental treatment is only available to those who need it least and is often flatly denied to those who need it most. This is retrograde and does nothing to improve our image in the minds of the population who pay for our services. Unchecked, this movement will end at a point where we are no longer regarded as professional workers whose status is tied up with the population's sense of our value to them. If we ever reach that point we are doomed and we become the ultimate example of the highly trained beauty therapist who never sees the real disease problems that his predecessors were brought up on. Victims of those diseases will remain hidden from public sight.

If we decide that we would like to remain a recognised profession, and if we can work with a Government agency that is tasked with providing primary and secondary prevention and if treatment and advice is to be provided for all those people living in deprived communities, then we will need to build a new, responsible profession that recognises its new role and is happy to discharge it.

We must employ the large numbers of support staff of all kinds we need to make the best use of our skills for as many of the population as possible. We must reduce as near to zero as possible the level of new disease. We must work hard to provide sound solutions to the problems of the elderly dentate, using evidence-based materials that have good track records. We must work to evidence-based care pathways that have been shown to be effective, and we must accept that success or failure may be more important than ever, now that patient inspired litigation is more common than at any time in our history.

De-professionalisation by successive governments

If an implant is needed, it should be available but why does it have to be so expensive? If a patient wants white teeth they should have them, but is a highly trained dentist needed to make it happen? These technical questions that we love to play with are almost irrelevant when judged alongside the biggest issue facing us in the early twenty-first century.

Do we wish to remain a profession and accept the societal responsibility that goes along with that

status? Or do we move inexorably down the slippery slope of de-professionalisation begun by successive Tory Governments in the 1980s and 1990s and carried on relentlessly by the current Government?

Other professions have gone down this path before us. I look across to my colleagues in teaching and the law and I can see how much damage they have suffered at the hands of the politicians. Politicians want the most of anything they can get for the least amount of money possible – that is their job – but we have to be strong and resolute if we are to fight off their depredations.

It was Nye Bevan – the driving force behind the establishment of the NHS back in 1948 – who was the first to recognise what it would take to buy the loyalty of our predecessors. It was in Newcastle that he said he would "stuff the consultants' mouths with gold". How right he was, and how much longer do we have to go on fighting against the dumbing down of our professional skills by his inferior successors?

In the short term the profession will almost certainly gain financially from adopting the ethics and the philosophy of the successful small businessman, but in the longer term we will be the worse off and we will never regain our hard-won status once it has gone. If we are to deploy the very best of new materials and the latest techniques to the advantage of the patients we serve, we must retain our genuine professional independence and we must be seen to be serving the whole population as best we can. If we try to do that we will gain the kind of respect we crave and deserve – and we will be paid well for our efforts. Therein lays the answer to the charge of 'gold digging' we have had to face as long as I have been involved in dentistry. Our GP colleagues have always been better paid by the NHS than we have, but I have never heard them referred to as gold diggers. Their efforts on behalf of the whole population have been noted by society and their remuneration has never been questioned.

One definition of a profession is that of 'an independent body of specially trained people, who demonstrate the correct demeanour of those who are highly educated and self-disciplined.' The greatest prize we have gained in the last 125 years is that precious status; let us not lose it in a distasteful race to make a better profit margin from our work at the expense of the very people we are supposed to be serving.

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