Other journals in brief

A selection of abstracts of clinically relevant papers from other journals.
The abstracts on this page have been chosen and edited by Paul Hellyer.

Dentists should not be the arbiters of who receives care

Holden A C L, Adam L, Thompson M. Private practice dentists' views of oral health injustice. *Community Dent Health* 2021; doi: 10.1922/CDH_00009Holden07. Online ahead of print.

There are few incentives to join publicly funded treatment schemes

In Australia, one-third of the population are entitled to receive publicly funded oral care, but due to funding constraints, only about 20% of those can receive it. Eighty-five percent of care is provided privately but dentists can apply to join the publicly funded scheme. Patients receive a voucher with details of the services to which they are entitled. Fees are fixed on a prescribed schedule.

This study examined the attitudes of 20 private Australian dental practitioners to patients who cannot afford care. Issues raised included the conflict between wanting to provide care and the realities of running a business, the feeling that *pro bono* work was overinvesting in someone else's problem, and a lack of appreciation, poor compliance and high demands from those who do not have to pay. Investing time in someone with high treatment needs *pro bono* 'might not be the best thing in the long term, if they're not willing to look after it.' Reservations were expressed about taking on publicly funded patients because they did not fit in with the 'type' of practice being built, but practitioners did sometimes act as the arbiters of *ad hoc* provision of free or subsidised treatment for individuals whom they judged were specifically deserving.

Practitioners may refuse to take part in publicly funded schemes due to poor remuneration and over-burdening administration. Despite some professional codes suggesting that refusal to treat on the grounds of race, colour, creed, sexual orientation or gender identity is unethical, refusal on financial grounds is not so considered and this may represent the neo-liberal view that privatisation of public services, increasing emphasis on personal responsibility for health and market forces now govern the provision of oral healthcare. The dentists interviewed felt that they had no role to play in managing the oral health inequalities in society and that the responsibility lies with government and public services. This point of view is 'troubling because it suggests that dentistry may be non-essential, rather than a professional activity concerned with amelioration of an important source of disease and social burden.'

If this stigma surrounding the most vulnerable in society is to be addressed, acts of individual charity by practitioners are not enough. Advocacy through professional associations to represent the values of a healthcare profession is needed, as is teaching a better understanding of the social determinants of health at both undergraduate and post-graduate level. The views of 20 Australian private practitioners may not be typical of all dental care professionals but should stimulate discussion about the role of the profession in reducing oral health injustice.

<https://doi.org/10.1038/s41415-021-3740-2>

Long-term 'drill and fill' will not work

MacDonald M E, Muirhead V, Doughty J, Freeman R. Critically engaging vulnerability: rethinking oral health with vulnerabilized populations. *Community Dent Oral Epidemiol* 2021; doi: 10.1111/cdoe.12703. Online ahead of print.

A deeper understanding of the social determinants of oral health is needed

For the purposes of their argument, the authors appear to have invented a new verb – to 'vulnerabilize' (in UK English, as opposed to US English, this should probably be spelt with an 's', not a 'z'), meaning to render a population, group or individual vulnerable.

'Vulnerable' as an adjective, the authors argue, is used as a cover-all word to describe a group or population which might somehow be at risk of something. Groups might be young, old, live in poverty, be recent migrants, a minority ethnicity or a combination of other factors; their vulnerability may be permanent or transient but the label of 'vulnerable' hides their identity. This also creates a binary in which everyone else is 'normal', and thus focuses downstream on 'vulnerable' groups whilst avoiding upstream engagement with 'the political structures and those who create and perpetuate inequity.'

Labelling others as vulnerable may prompt charity and benevolence, may perhaps ensure some level of safeguarding, and may bolster political agendas to help the needy and deserving. However, in such simple labelling, the complexities of people's lives are lost – 'there is no thing as a single issue struggle, because we do not live single issue lives.' Such labelling also implies that the vulnerable are victims and that someone with power is deciding which group is deserving of, for instance, being the next subject of research into their oral health.

Words colour our attitudes. We have hopefully removed the term 'the disabled' from our vocabulary, replacing it with 'people with disabilities' (person-centred) or 'disabled people' (identity-centred). Disability alone, however, does not necessarily render someone vulnerable. It is the social constructs of steps and stairs which handicap and marginalise.

The authors argue that it is this social process of being 'vulnerabilized' which needs to be addressed. Researchers need to look both upstream to socially sanctioned processes and downstream to understand the complexities of people's lives, otherwise oral health research will only ever have partial successes.

Engagement with groups with whom researchers work is essential, entering into dialogue to discover the terms by which they would want to be known and therefore beginning to understand the complexities of their lives. Multidisciplinary collaborations with researchers external to oral health research will be important, as will community-based initiatives in which research questions, aims and outcomes are mutually decided. Social and structural determinants of oral health should be integrated into undergraduate and post-graduate education.

<https://doi.org/10.1038/s41415-021-3741-1>