EDITORIAL

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I was once told that the reason for 20 March being designated as World Oral Health Day each year is because when the date is written as 3 20 it represents the number of teeth in each of the adult and deciduous dentitions, 32 and 20. It seems somewhat tenuous and distinctly convoluted but at least makes a good story.

Whatever contortions one makes of 32 and 20, the essential factor is that they are numbers and as such, measurable. Less than these totals and one has a shortened arch, is partially edentulous (being very pernickety I have never been sure that partially edentulous is correct, one is either edentulous or not, however…) or *sans* dental hard tissues. More than these numbers and other conditions arise such as oligodontia and supernumeraries. But measurable they remain in a way that other body parts fail to emulate. One liver, two kidneys, ten toes; you can make your own list. This would remain of only passing observational interest and of conversational nicety were it not for the overriding important consequence that being measurable it is possible to pay someone to do something to a tooth or teeth on a per unit basis. At one and the same time, this is both the driving force and the Achilles heel of the business of dentistry.

Systems of health care are paid for either by time or by unit (piecework). What makes dentistry different from almost all other branches of medicine, if indeed it is a branch of medicine, is the practical clarity that it is so amenable to being financed in this way. How is it possible to pay a renal consultant on a piecework basis? What rate of remuneration can be applied to a psychiatrist in terms of mental health patients counselled given the varied extent of time commitment? The unfortunate, essential difference is that dentistry is for the most part paid for primarily on a measure of quantity and not quality. Don't misunderstand me. I am not saying that dentistry is poor quality. Far from it, the standards of care and of clinical excellence are commendably high as is overwhelmingly illustrated by the content not only of each issue of the *BDJ* but in many other places. But the net result of constant quantitative calculation is a mindset that places the industry or profession as one which is involved in counting rather than caring. Making widgets rather than consulting with them.

I use the word unfortunate because this notion is profoundly buried in society's psyche. The expectations are that a dentist, maybe even another dental health professional, will treat or fix a tooth or teeth, do the job and be paid by some means or another. In contrast, when we visit a medical professional, whilst we expect an outcome, in the overwhelming majority of interactions we do not expect to be able to quantify it. 'He said that the rash was probably an allergic reaction and I shouldn't worry', 'she said that they could run some tests if it didn't improve in a week or so'.

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It is because of this ingrained fiscal model, putting the Treasury back in the mouth, that I suspect that minimal interventive dentistry is currently finding it harder to make inroads. Although unquestionably it is making significant progress. The notion of anticipating consulting about one's teeth is somewhat alien to the majority of patients. So, the idea of holding detailed discussion about diet, plaque, oral hygiene routines, the application of fluoride and being expected to collaborate in one's own oral health, rather than have it 'fixed', requires the generation of a whole new mindset.

One curious exception to this is aesthetics. When appearance is invoked, the patient does expect to be consulted as to their views on what should, or should not, be done. Taking time to discuss these qualitative decisions seems quite in order *and* it is understood to be part of the cost of the whole procedure. That is, there is an acceptance that there are both qualitative and quantitative aspects to the encounter. Yet, bizarrely or perhaps understandably given the above, these activities are often not considered to be essential dentistry but side issues of choice. While almost universally accepted that cosmetic dentistry should not be paid for by the state, a cardinal difference is the recognition that it is not only quantitative.

The problem of trying to change attitudes to payment systems lies as much with this historical perception as it does to any attempt to persuade on the basis of epidemiology, access, inequality or affordability. But it is not only the rest of the world that is stuck on this model, it is the dental profession too. How many of us know what our hourly rate is, or should be? To what extent do we feel comfortable being paid and not 'doing' something with our hands? We should stop thinking 'how many?' and start thinking 'what value?'. ■

https://doi.org/10.1038/s41415-022-5310-7