Prevention in practice

Wayne Richards
Professor of Community Dental Practice, Glamorgan University
Email: wrichard@glam.ac.uk

Send your comments to the
Editor-in-Chief,
British Dental Journal,
64 Wimpole Street,
London
W1G 8YS
Email bdj@bda.org

Since the introduction of the new dental contract in England and Wales in April of 2006 many general dental practitioners (GDPs) have voiced the opinion that it has failed to enable dentists to develop prevention within their practices. Since prevention is the cornerstone of care for future improvements in oral health we need to know why GDPs feel the way they do.

What is meant by prevention in practice? Is it having a hygienist in a surgery providing 'hands on' scaling and polishing? If so maybe the new contract does not facilitate this approach, indeed the evidence suggests that this would be a poor use of resources since prevention is far more sophisticated than routine scaling and polishing.

Primary prevention is about developing a healthy 'dental career' in individuals. This is achieved through oral health promotion enabling individuals to adopt healthy behaviours from birth. Secondary prevention is about changing behaviours to achieve disease inactivity in individuals who have adopted unhealthy lifestyles. Tertiary prevention is about the treatment of resultant pathology together with behavioural changes. Since the effectiveness of prevention in practice has been questioned by numerous workers, how can it be made more effective? Do we need more 'time' to be able to put it into action? The message from 'behaviour change' literature is that effective prevention needs to be opportunistic and 'patient centred' rather than prescriptive and 'appointment-book centred'.

CHANGING BEHAVIOURS

Primary prevention needs to occur at population, community and individual levels; the dental practice is ideally situated for the latter. And this is the tip of the prevention iceberg. Secondary preventive opportunities can also be taken by the whole dental team in the practice. Clearly the preventive orchestra need to have a conductor and who better than the dentist?

Dentists have in the past been faced with a population which has experienced high levels of dental disease and as such have been swamped with the need for tertiary prevention. In this context much of the emphasis of the dental experience was on treatment. This focus has resulted in organisational models designed for just that. Kevin Lewis has written 'Was the preventive care actually effective? Were we promoting oral health, or simply promoting the practice's reputation and increasing referrals and recommendations?' in reference to his traditional preventive approach using hygienists and dental health educators.[1]

We are now faced with populations that experience lower levels of disease with its distribution skewed within society at large. We are all familiar with the 80:20 rule, in that most of the disease (80%) is found in a small proportion of the population (20%), usually deprived. Therefore, collectively, deprived populations have the most to gain from prevention – primary, secondary and tertiary. Deprived sub-groups have traditionally used dental services less frequently in a 'symptomatic' fashion. However, this 'symptomatic' attendance provides dental personnel with a preventive opportunity so as to encourage an alternative 'asymptomatic' approach to care. This opportunity requires little time yet is secondary prevention in practice.

To make preventive advice more effective dental personnel need to be sensitive to the cultural norms and expectations of deprived sub-groups in our populations. It is important to be aware of the different linguistic codes used by different social groups and how misunderstandings result from mixed communications. It has been reported that higher socio-economic groups use an elaborate code while lower socio-economic groups utilise a restricted code. Again there is no time implication in using an appropriate communication code.

Behaviour change occurs at different paces in different people and the rate is influenced by many variables. The first stage of any behaviour change is the recognition that it is necessary. Using the example of smoking, most people are aware of its consequences and many recognise the need to give up. If an individual is unsuccessful in 'giving up' at the first attempt, the failure does not mean that the individual does not want to give up, rather that the barriers are greater than the facilitators. A skilled helper recognises this.

So why is it that GDPs feel that time constraints prevent them putting prevention into practise? Possibly prevention is perceived as 'items of hands-on treatment' rather than an opportunistic approach to the delivery of care, which may need some organisational changes orchestrated by the dentist. Also, the application of prevention in practice requires as skilful a technique as that required for the extraction of a molar. The skills are different but each has recognisable components as highlighted in The Department of Health's *Improving Health: changing behaviour NHS health trainer handbook*.

An improved preventive approach can only benefit all concerned – patients, dentists and the community at large. Observable improvements in community oral health would certainly define us as health carers. And where does time come into the equation?

1. Lewis K. *The Dentist.* March 1997.

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