One on one

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Earlier in the year I was kindly invited to give a presentation to a group of Belgian colleagues in the picturesque city of Bruges. The study club, for such it was, consisted of general dental practitioners from various parts of the country who had assembled to hear me, amongst others, talk about oral medicine, communication and the future of dentistry.

One important factor to note is that in Belgium single-handed practice in the majority of cases means just that (actually that's not strictly true, dentists do of course use both hands). But, it is true in that there is no dental team nor a concept of one. There are no hygienists, few dental nurses and the practitioner performs all the tasks that on this side of the Channel we rely on a variety of other professionals to complete.

Let us set aside for a moment the quite ghastly image of having to manage patients and practice without help and support and also suspend all we know and love about the dental team. The business of dentistry, the clinical intervention, is about one person treating, attending to, concentrating on, however one wishes to express it, one other person. It happens in other health and service sectors too; hairdressing, chiropody and massage to name but a few. Arguably general medical practice falls into the same category while secondary care especially that such as surgery requires a fuller team all of whom are needed to enable the care to be delivered.

VENTURE CAPITALIST RAIDING PARTIES

But what of this? I raise the issue because I am not sure of the extent to which we consciously acknowledge the 'one on one' fact in our thinking about the provision of dentistry. The central truths are that it costs whatever the operator's costs are to provide this; that only one patient can be operated on at any one time; and that the patient can only receive dental treatment from any one operator at any one time. Obvious of course. Yet why is it, for example, that each now and again a collective of supposedly very clever venture capitalists descend on dentistry in the form of a raiding party intent on making what they see as huge profits because, as everyone knows, there is apparently loads of money to be made from dentistry and oodles of potential for expansion?

Forgive me if I am wrong but it seems to me that there are only two main routes that provide income in a dental practice, either fees for professional (clinical) services or sales of associated products or merchandise. Money from the latter can be increased by selling more. This might also be true of the former but it has to be either as a result of the availability of more expensive options or the provision of treatment that might not be strictly deemed 'necessary'. This is perhaps where conflict might arise between a for-profit organisation that owns practices and a clinician whose job is not to sell but to provide treatment that he or she thinks is appropriate. From a company's point of view there may well be savings to be made from multi-practice ownership through bulk purchase and economies of scale but the notion that somehow merely grouping dentists together alters the one on one basis of care delivery is completely fatuous.

But if this is a well established principle for providing dental treatment, what happens when the need for treatment falls away? The Belgian dentists looked variously terrified and bemused by my suggestion that in future we might become a profession of dental physicians rather than dental surgeons. However, will we need to seek a different model of remuneration? Will patients be prepared to pay for consultations rather than active one on one sessions where something measurable is 'done'? Is the price tag for oral health advice perceived as being greater or smaller than for, say, a restoration or an implant? How much more or less would a patient be prepared to shell out for being seen through the direct access route by a hygienist or therapist?

Certainly the NHS contract which ran for many years through the second half of the last century had the matter at its heart, as did the profession, albeit without really realising it. The fee-for-item-of-service system was taken at face value and led to us developing many pieces of equipment (the air-rotor included), techniques and methods that enabled us to work faster and more efficiently, optimising the one on one principle to elicit the greatest return for effective treatment.

Whatever happens in the future with regard to the next NHS contract, falling or rising disease levels, access to oral care and technological developments such as stem cell therapy it is difficult to see how the basic model of one lay person being attended by one professionally trained person will ever change. While the notion of team working is certainly here to stay for the foreseeable future it is also well to ponder other methods of oral care delivery and fascinating to speculate on how the model of dentistry in Belgium might develop in the coming years. Given the human condition that everything is cyclical how long before we are back there ourselves?

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