Response and responsibility

Stephen Hancocks OBE
Editor-in-Chief

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

The radical reduction in the caries rate and the concomitant improvement in oral health in the UK in the last forty or so years has had, and will continue to have, equally radical effects on the way in which dental care is delivered, and received.

A recent seminar conducted as a round table panel discussion in front of an invited audience of dental professionals and members of the media served to underline this. Various subject areas were considered in turn such as consumers' expectations of what NHS dental services should deliver, market studies such as the recent Office of Fair Trading report and the cost of a non-preventive approach. Much turned, inevitably, around the matter of finance and methods of payment. As is now regarded as a matter of historical fact, the fee-for-item of service contracts on which the NHS dental services were based for many years in the last century were described as having achieved their goal of improving oral health by dealing so efficiently with the enormous backlog of untreated disease present from the time of the formation of the NHS. But is that really true? Surely the main factor that has delivered us to our current situation has less to do with the system of remuneration and very much more to do with the commercial introduction of fluoride toothpaste? Deliberations about the current NHS dental contract with units of dental activity (UDAs) and the potential for future change with pilot schemes testing capitation and payment for prevention would not even be possible if it were not for the decline in caries. If we were experiencing similar caries levels now to those in the 1950s and 1960s there would be no debate; there would still be a fee-for-item of service arrangement to continue fighting the fire of unending decay and its consequences. But there isn't.

QUITE A DIFFERENT GAME

Instead, our increasing understanding of the caries process, ways in which to most effectively prevent it and minimise its impact on oral tissues is more obviously dictating our response to managing the care of our patients. Here we come upon another very interesting shift in culture. No longer are we as professionals the sole gatekeepers of our patients' health, or at least what used to be regarded as health but was really disease management through surgical treatment. We are now partners in the genuine activity of advising patients on their responsibility for their own oral health when we are not physically there to guide them; which is the overwhelming majority of their lives.

This co-existence of response and responsibility requires the playing out of quite a different game. To begin with, it calls for a much improved level of communication. Simple oral health mantras such as 'not to eat sweets' and 'to brush your teeth after meals' are now almost laughably discredited as being ineffectual. Yet these were the apparent truisms on which the professional-patient relationship was hung and maintained for many years. Perversely, there was a reassuring solidity to it, a familiarity that kept the public expectation of regular six-monthly fillings as an inevitability of life and the cyclical provision of restorations as the inexorable foundation on which the income of the practice was based.

Looking ahead, and not so very far ahead, all this must change. There will always be an element of an expert-lay relationship because we are by our training equipped to offer advice and diagnosis to help (and treat) our patients. But the days of the response to offering a choice of treatments as 'whatever you say doctor, you know best' are dwindling as fast as new connections to the internet are growing. We might not all be authorities in all fields but we are of increasing proficiency at knowing our rights and applying what information we are able to gather to given situations.

Which is again where our future role in managing patients' expectations and fostering the philosophy that they are as much in charge of their own oral health destiny as we are, in fact more so, will come to play an increasingly important part of our work. Several elements of this transition need careful consideration. It requires more time and greater communication skills, both of which cost money. It also bumps up against that timeless problem of how does one prove that prevention is working, other than saying 'look it hasn't happened because of what I told you'?

We also need to consider what happens when the crutch of the professional blame culture is taken away; when the excuse of regular attendance providing a convenient cover for a lack of regular effective self-care no longer cuts any ice. There needs to be serious assessment of the extent to which a contract derived from the current NHS pilots addresses these issues but we will also need to look to the private arena too. To what extent will patients empowered with the knowledge that their oral health is almost all now in their own jurisdiction decide they still require our services? How will we respond to that challenge and what responsibilities will it entail?

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