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**

Consumerism v. professionalism

Consumer-driven and commercialised practice in dentistry: an ethical and professional problem?

Holden ACL. *Med Health Care Philos* 2018; DOI: 10.1007/s11019-018-9834-1
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Who profits from the dentist/patient relationship?

Socrates asked Thrasymachus '.... tell me .... is your physician a money-maker, an earner of fees or a healer of the sick?' The potential conflict between the provision of healthcare and the running of a profitable business is thousands of years old, but is it relevant today? Dentistry has traditionally been provided by entrepreneurs, setting up practices wherever there is a perceived demand for their services. This paper asks whether the potential conflict between the practitioner's need for profit and the needs of the healthcare consumer is a valid concern.

Increasing normalisation of the term 'health consumer' or 'client' could indicate that the transaction between professional and patient has become a purely commercial one. However, the empowerment of the consumer has given rise to a more equal relationship between clinician and patient, leading to a more collaborative approach to care.

The prime function of a dental business, though, should not be 'business' but to 'empower consumers of healthcare to access treatment that they need'. There is a clear difference, however, between what the patient needs and what the patient wants. For instance, the profile of elective cosmetic treatments available has risen rapidly in recent years. Their provision to benefit patient appearance should not damage the clinical/patient relationship, unless that want is generated and sold purely to the commercial benefit of the practitioner. The risk of over-medicalisation, by sowing seeds of discontent in the patient about their appearance, is high. But it is not for the professional to judge what is, and what is not, appropriate for the greater good of the patient. Here the collaborative approach to care, with understanding the patient's needs and wants, acts as argument against the accusation that selling cosmetic treatments is unethical and driven by the need for profit.

Other commercial considerations threatening the clinician/patient relationship include the increasing availability of whitening (in some jurisdictions) and injectable fillers by non-dentists, and the competition for patients from advertising from other dental practices. Demand for the perfect smile or tooth shade may also be driven by toothpaste and toothbrush manufacturers.

The commercial nature of general dental practice is unlikely to change in the future so practitioners should strive to maintain 'inherent virtue' in the provision of their services, whether wanted or needed by patients. Failure to do so leaves patients in the hands of those who are here today, gone tomorrow, seeking only profit where they may.

DOI: 10.1038/sj.bdj.2018.385

Poor oral health is a predictor of frailty in old age

Influence of poor oral health on physical frailty: a population based cohort study of older British men

Ramsey SE, Papachristou E, Watt RG *et al*. J Am Geriatr Soc 2018; **66:** 473–479

Dental care professionals could play a role in the prevention of frailty

Poor oral health has well recognised effects on eating, swallowing and nutrition as well as speech and smiling, and therefore has consequences for many aspects of health and well-being. Previous studies have suggested that poor oral health is also associated with a greater risk of frailty. With an increasing ageing population, frailty in older people has become a major healthcare challenge. Frailty in this paper is defined as 'a state of vulnerability in older age to adverse outcomes, including functional decline, hospitalisation, disability, long-term care and death'.

Using data from the British Regional Heart Study (7,735 men recruited age 40–59 from 1978–1980), survivors in 2010–2012 were called for re-examination. Measures of oral health included tooth number, pocket depth of six index teeth (three upper and three lower teeth), attachment loss and self reported oral health. Self reported measures included dry mouth, sensitivity and eating difficulties. Frailty measures included physical measurement of weight, height and girth, walking speed and grip strength. Medical history recorded included coronary heart disease, diabetes, and the regular use of medications with known xerostomic side effects. A smoking history and socio-economic status were also recorded.

Edentulousness, dry mouth and cumulative self reported oral health problems were associated with the incidence of frailty. These findings were independent of other general health issues and socio-economic factors. The relationship between poor oral health and frailty is not well established. However, dry mouth, often a side effect of polypharmacy, affects oral health-related quality of life and may influence the comfort of the mouth and of dentures in particular. There may then be a consequent effect on nutritional status, although self reported eating difficulties were not found to be a significant factor.

The authors conclude that oral health problems may be powerful markers and predictors of frailty in older people. Unsurprisingly, they state that 'oral health is under recognised in the assessment and care of older people' and it is encouraging that this study has been published in a journal of geriatrics and not a dental journal. Further research is needed to investigate the links between oral health and frailty, and whether they are associated through nutrition or inflammation. The authors also recognise that poor oral health may be a modifiable risk factor for frailty. Sadly, it is not suggested that a dental care professional is routinely involved in the assessment and care of older people.

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