'Teeth have become the new boob job' *vs* 'Suffer the little children'

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General Dental Practitioners (GDP) operate not only as clinicians but in addition as business persons. This paper explores the tension between health and beauty for GDPs in dental practice. The question of professional position is debated. Change management applies to business models in any business when 'market need' changes. Clearly marketing can improve demand but whether that demand is morally appropriate or sustainable is a question that faces policy makers in dentistry. The authors present arguments to promote the development of services on a profession based on oral health.

Lauren Cochrane wrote a piece in *The Guardian* earlier this year in the Fashion section 'Teeth have become the new boob job': the rise of oral tweakments'.[1] Is this a fundamental professional position for GDPs to consider? We expect that there would be strong opinions on both sides of the health/beauty spectrum. Where would the bell shape fall (Figure 1)?

If dentistry is a profession founded on health principles, there is a strong argument that it is necessary to provide equal opportunity for populations to have availability and access to dental services. The World Dental Federation (FDI) recognise this in its promotion for coverage of populations worldwide.[2]

The starting point for health is to consider the aetiology of the two main dental diseases, caries and periodontal disease. Focusing on caries, it is clear that caries can be controlled through the behaviours of individuals. As it is a disease where cavities can be prevented[3] then one should ask why are people not behaving appropriately?

Dental public health practitioners promote regular attendance at the dentist according to published guidelines.[4,5,6,7,8] Registration, whether defined as a contract or conceptionalised as a psychological contract, provides GDPs with the opportunity to communicate the desired behaviours required for disease inactivity. More recently non-dental personnel have also been engaged in primary prevention advising attendance at the dentist along with brushing and sugar control.[9,10] One obstacle non-dental oral health educators experience is the inadequate availability and therefore access to GDPs.[9,10] This is totally disheartening to someone advising a behaviour where the person advising knows that this outcome is impossible.

Many would say that more dentists are needed to provide adequate coverage. However, if the workforce is prioritising oral tweakments while believing that population coverage is not their responsibility, then the argument of increasing the number of dentists does not apply, demonstrated in previous research.[11] Instead, different approaches to the delivery of care by GDPs need to be addressed if coverage of the population is to be achieved.

A recent paper by Ronnie Levine highlights the need to address relatively high levels of caries in populations[12] and cites an editorial by Stephen Hancocks 'Suffer the little children'.[13] Levine makes a strong case for water fluoridation as a mode to reduce the suffering for the children experiencing multiple caries needing general anaesthesia. However, Levine recognises that fluoridation alone cannot reach all groups when he states that the least deprived groups show no difference in caries experience between fluoridated and non-fluoridated areas. Take for example the North West of England to show the difference in caries prevalence and severity in Table 1 and Figure 2. While there is an enormous benefit for population approaches to influence health, one should not forget the strategic need for additional targeted approaches to provide care in order to improve and equalize public health outcomes.

Previous considerations have been given to population health and identify that upstream population approaches have the potential to increase social division, when individual behaviour change is necessary within populations.[14,15] Water fluoridation will reduce the prevalence of caries in populations including the socio-economically deprived.[16,17]. However, the distribution continues to be skewed towards the deprived.[18] Individual behavioural factors impact on disease aetiology and unless the behaviours change, disease activity persists in individuals. Targeted approaches have the disadvantage of stigmatising those targeted. High street general dental practices provide the perfect situation for delivering care in a targeted approach that does not stigmatise the patient.[19] This way a cohesive 'joined up' strategy can be manifested where rhetoric becomes practice; non-dental oral health educators can advise attendance and dental teams can deliver and consolidate messages.

Previous research highlights the fact that downstream behavioural approaches have failed for the children who have multiple caries and require general anaesthesia for

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multiple extractions.[12] Relying on reducing the prevalence without significantly impacting the severity of the disease results in a proportion of children continuing to behave in such a way that creates disease active oral environments and caries activity. Previous research concludes that improvements are required in strategies employed to support high caries risk children pre and post dental general anaesthetic to facilitate higher incidence of attendance and preventive interventions with primary care dentists.[20] Therefore, there is a case for a population approach but also a simultaneous strategic behavioural tailored approach.[21]

Dental public health practitioners refer to the three A's; Availability, Accessibility, Acceptability of services.[22] If behavioural approaches have not worked in the past should we be exploring the acceptability of services to those groups who are not responding? Researchers have explored the perceptions of GDPs and their teams regarding multiple caries in children and identified obstacles for individuals receiving oral care.[21] These include the financial incentives for the delivery of care but more importantly the perceptions they held regarding non-compliant patients and stereotyping the individuals.

In his editorial 'The pieces of the caries puzzle align', Nigel Pitts promotes the global consensus for Achieving a Dental Cavity-Free Future (ACFF).[3,23] He poses the question of whether dentists are ready to move from operative to non-operative preventive treatment of dental caries in clinical practice. Dental public health professionals have voiced the opportunity arising from the COVID-19 pandemic in catalysing change towards non-operative preventive treatments for caries.[24] The delivery of non-operative preventive treatment, termed Minimally Invasive Oral Care (MIOC) is now promoted from a sound evidence base.[25] However, for this to become mainstream in clinical practice for GDPs, changes are needed in helping GDPs develop the skills to deliver acceptable services for those patients who have, in the past, failed to comply with advice. These include modifying the demand for services from both high and low socio-economic groups. Along with this the financial incentives need to recognise the successful delivery of managing demand. Past business models have failed to do this, favouring a model based on supply induced demand and oral tweakments shown in Figure 3.

Managing demand involves changes for both upper and lower socio-economic groups. Control of mitigation is within the domain of dental professionals. Actions will demonstrate where the bell shape curve will/has fall(en) in the future. This brings us back to the question of health or beauty?

During the COVID-19 pandemic we have all observed and understand the need to reduce the curve of demand for services in order to avoid flooding the health system. This applied across the world regardless of the paymaster. Some counties have been more effective doing this than others. It is our opinion, if the dental profession can provide coverage to the whole population it demonstrates that it is a health driven profession keeping the access curve at a level

Fig. 1 Bell shape curve of Workforce Opinion

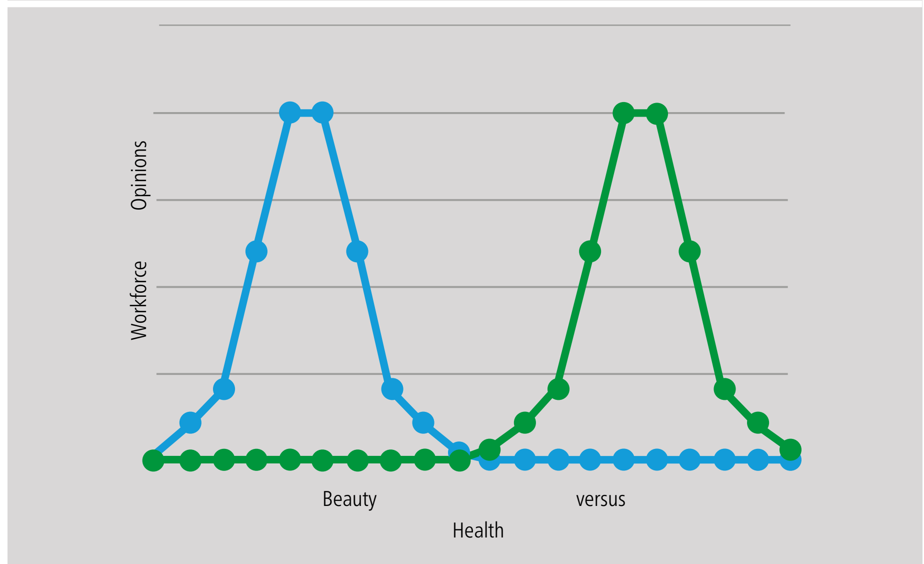

Table 1 Caries in the North West of England Best and Worse regions

	England	Blackburn & Darwen (Upper and lower tier) WORSE	Cheshire West and Chester (Upper tier) BEST	South Lakeland (Lower Tier) BEST
dmft	0.8	2.3	0.6	0.4
% with caries	23.4%	50.9	22.7%	18.4%
dmft for those with caries	3.4	4.6	2.6	2.2

Fig. 2 Deprivation profiles of best and worse regions

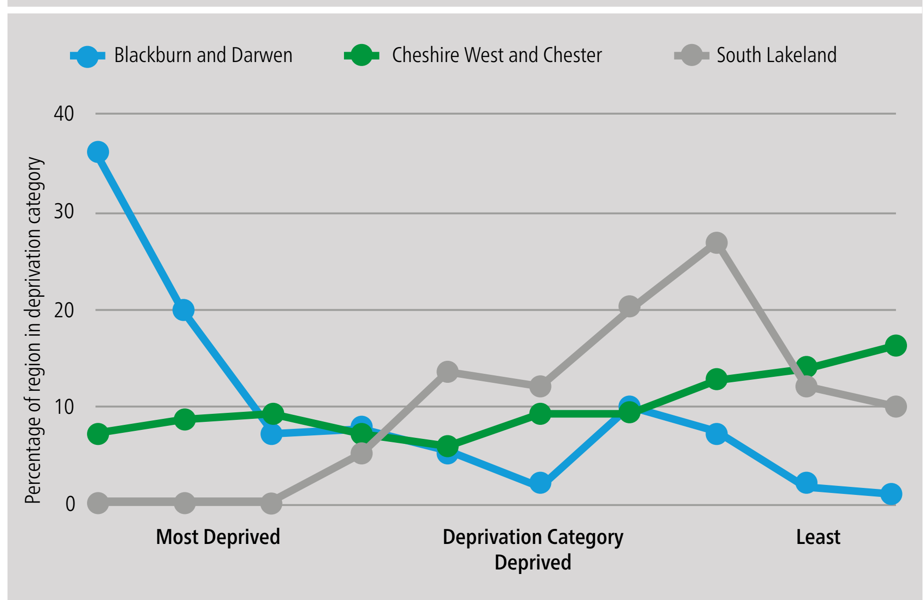

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Fig. 3 Current hypothetical care delivered by workforce

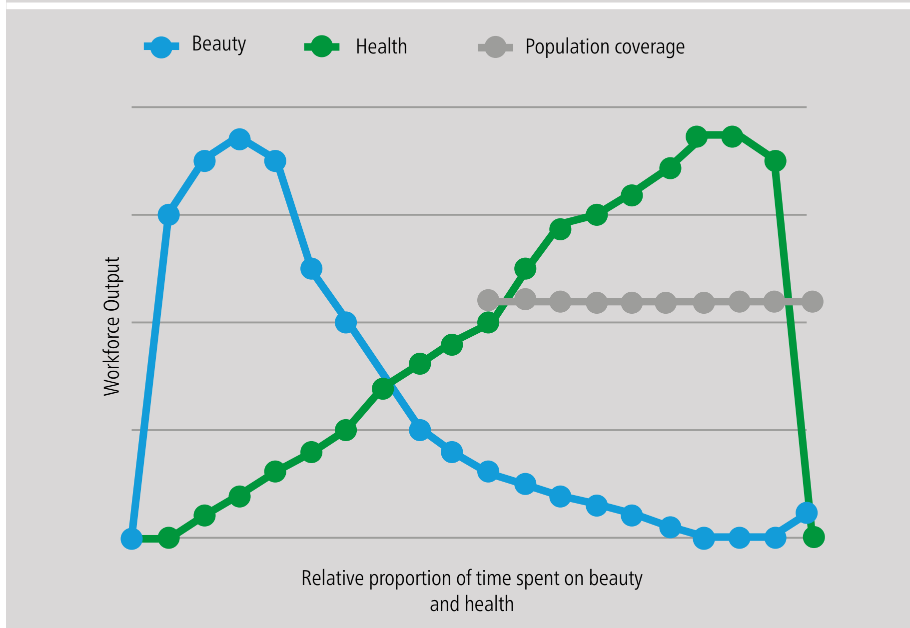
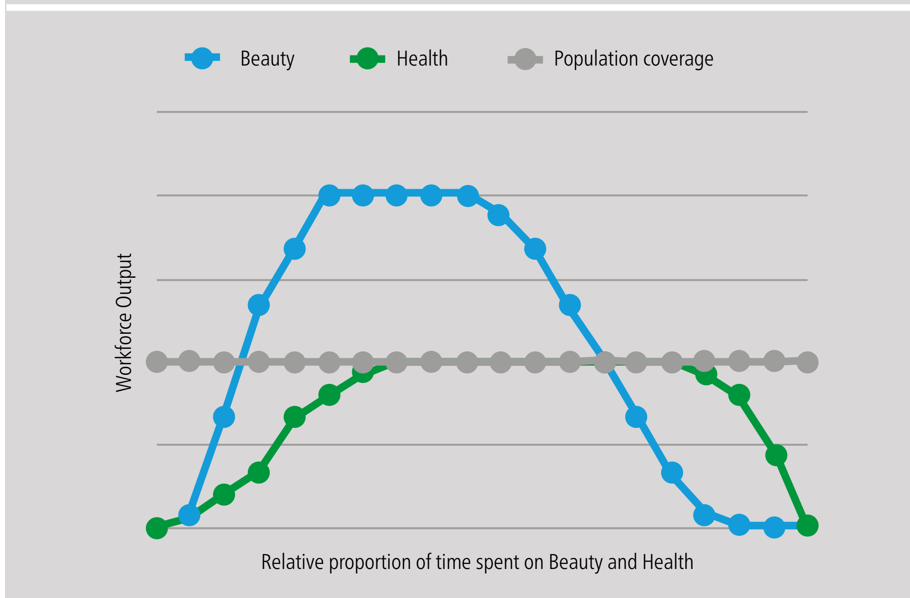


Fig. 4 Balanced care delivered by workforce



where services can absorb the need rather than the demand shown in Figure 4. Making clear to the population when demand is based on need or social wants is a fundamental requirement for a professional approach. Furthermore, the application of behaviour change principles to generate a 'demand' for behaviours such as appropriate attendance at the dentist (oral health prevention) certainly shows a profession firmly grounded in health.

To quote Martin Luther King Jr 'The ultimate measure of man is not where he stands in moments of comfort and convenience but where he stands in times of challenge and controversy'.[26] These are very challenging and controversial times for dentistry, we are sure that the dental establishment will show its true standing.

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