



## EDITORIAL

## Social dentistry in dental education.

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In the last semester our team of colleagues of the school of dentistry at Universidad de Concepción gave two courses focused on social dentistry.

The first one was "Oral health guidance/counseling", which included topics such as cognition, emotion and motivation that lead to the health beliefs model, transtheoretical model, stages of change, and motivational interview.

The second was "Social determinants of oral health," which included topics related to social cohesion, health inequities, oral epidemiology, the dentist's role, and structural and intermediate determinants of health.

A third course focused on social dentistry was "community and collective dentistry", but it could not be given for various political and logistical reasons.

At least in Chile, when we talk about social dentistry, the first thing that comes to mind is the implementation of dental care campaigns or missions to places with limited access to oral health care.

Although the real motivation of the participants in these campaigns is often criticized, it is undeniable that many people benefit from dental treatments.

A disadvantage of these treatments is that they focus on actions that improve functionality and aesthetics, but do little about the causal and perpetuating factors contributing to high levels of oral morbidity in a specific sector of the population.

Although it is difficult to separate perpetuating factors from causal ones in oral diseases, the analysis is based on an approach that focuses on lifestyles and another one more up-to-date focused on social determinants of health.

The first approach is the one we tried to use in the oral health guidance/counseling course through the practice of strategies that create healthy habits in our patients so

they are able to maintain a good oral health.

The second one was used in the course of determinants of oral health, in which we tried to analyze the factors that make us an inequitable society in terms of health coverage (and practically all other areas) and the elements that may contribute to this inequity.

During the course we realized that there were students interested in these subjects and who were able to reflect critically on various subjects.

However, we also noticed that the "clinical vision" is the one that prevails when providing solutions to the problems of inequality in oral health.

The "clinical vision" is one in which the only or best way to improve the oral health status of the general population is to clean, fill, and extract teeth.

I do not intend to say that improving access to dental treatments does not contribute to reduce inequality in oral health, but it cannot be considered as "the solution".

Given the above, I propose two questions:

Do we know an effective and efficient strategy to eliminate inequality in oral health? And are we, dentists, called to lead the implementation of that strategy?

I am afraid that for both questions the answer is "no".

Firstly, we live in an unequal society in which disparities in access to oral health care are more a consequence than a cause.

Secondly, we have little knowledge of how to implement strategies and, worse still, dentists get financial benefits from this inequality.

This reminds me of one of Upton Sinclair's quotes *'It is difficult to get a man to understand something, when his salary depends on his not understanding it.'*

Dentists ignore the answer and those of us who are already working as dentists will probably always prefer to ignore it. But it is not acceptable that as dentists



and especially as academics we do nothing about it; it is unacceptable not even try.

At the moment I think the best way is to create and maintain spaces for critical reflection in undergraduate courses. By contributing with our basic knowledge of social dentistry and health inequity we may be able to

get future dentists to answer "yes" to the two previous questions.

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