J Oral Res
oral and craniofacial sciences

Editorial

Reflections on promotion and prevention in dentistry, part 1.

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Conflict of interests: None.

Acknowledgements: None.

Cite as: Cartes-Velásquez R. Reflections on promotion and prevention in dentistry, part 1. J Oral Res 2017; 6(8):196-197.
doi:10.17126/joralres.2017.061

We are about to finalize a research project that evaluated the effect of an intervention based on Motivational Interviewing that was implemented in the homes of disadvantaged preschool children.[1]

One of the products of the project is a book entitled *Entrevista Motivacional en Salud Bucal* (Motivational Interviewing in Oral Health).[2] In this Editorial as well as in next month's, I will present the final reflections on the main subject of the book, the execution of the research project, and especially the way in which dentists carry out promotion and prevention in oral health.

Throughout the book the objective has been to generate, or at least try to generate, a questioning of the way in which dentists approach health promotion and prevention in dentistry. That is the first stage.

Most of us, the dentists, use the prescriptive approach of "oral health education" to carry out promotion and prevention, probably due to our professional training and experience. I have the impression that our historical role as an elite profession has likewise led our methodological approach in that direction.

In a way, it seems that we have confused "empowerment" with "appropriation" of oral health. While empowerment leads to the taking of responsibility, constructive leadership and collective work, appropriation leads to imposition and prescription from the one who knows to the one who does not.

By discussing and explaining the principles of Motivational Interviewing in oral health, I hope that in some measure it will serve to generate new professional resources and improve the impact of promotion strategies and prevention in oral health. That is the second stage.

Questioning the appropriation carried out by dentists in a time when the professional market is saturated, when dentistry has lost its elite position in higher education (see PSU cutoff scores) and its socioeconomic status (see employability and salaries), is a call to review our social role. Times have changed and we hope it will be for the better. This is the stage zero, the foundations.

When we started this project, we strongly believed that our approach was comprehensive; we had covered the area of cognitive aspects (Oral Health Literacy) and the area of emotional-motivational aspects (Motivational Interviewing). Moreover, both areas seemed well integrated; it was basically a single body of knowledge.

ISSN Online 0719-2479 - www.joralres.com © 2017

But, now that we have the results of the project we can say that we were only partially right.

The central goal of the project was to reduce the incidence of caries in preschool children using the Motivational Interviewing; we succeeded. The complementary goal was to increase levels of Oral Health Literacy; nothing happened. We cannot show you the complete results, but they will soon be available in your favorite public dental health journal, that is what we (the authors) hope.

Everybody is wise after the event. Many might say that it was quite obvious that the intervention could help reduce the incidence of cavities (there is abundant evidence of that) and that this would not necessarily be related to an increase in literacy. That also seems obvious to us now, but obvious things require analysis.

The evidence was clear, higher levels of Literacy in Oral Health correlate positively with better oral health status; more use of preventive measures correlate with higher levels of oral health related quality of life.

We assumed that the intervention included in this project would motivate people to learn more about oral health, in fact, in the home visits people were taught the typical contents of oral hygiene. Therefore, motivation to learn along with teaching should have increased the levels of Oral Health Literacy.

But the Motivational Interviewing is not about content, it is not prescriptive or banking education (according to the concept proposed by Paulo Freire); the Motivational Interviewing focuses on competencies, on resources. The contents are only a part of the competencies; even skills are only a part of the competencies. These parts are only complete if they include the motivation and the emotions associated with the execution of a behavior that the subject knows how to execute.

The latter reinforces the first and second stage mentioned above. Prescriptive education should not continue to be used for promoting oral health. We must use strategies that contribute to generate (intrinsic) motivation in our patients, who are the empowered agents of their own health.

It seems that this exaltation of the emotional aspects leaves content completely aside, as if knowledge would not matter, only the patient's willingness. Does this contradict the evidence presented in the first chapter of the book? The truth is that we have some reasons to believe that the content matters little, at least in the population that participated in the project.

Before the intervention, in the first stage of the project, we evaluated the relationship between several variables. We hoped to find what we already stated above, *i.e.*, more literacy correlating with better oral health. However, the correlation between the two variables was almost zero.

We could hypothesize that having knowledge, health literacy, is a first step or input to achieve good health. But, what good is knowing how to brush your teeth if you do not have money to buy toothbrushes, or if social pressure leads you to spend money on other things or goods, or to have a highly cariogenic diet.

The implication is that, at least in the population of our study, Oral Health Literacy plays a marginal role as a variable or incident condition in having good or bad oral health. Therefore, I insist, we must leave in a second or third place the simple delivery of content, *i.e.*, prescriptive education.

In next month's Editorial I will discuss other lessons that the project has taught us, which are relevant to evaluate and modify the way we carry out promotion and prevention in oral health.

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