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Editorial

Reflections on promotion and prevention in dentistry, part 2.

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In last month's Editorial[1] I reported some of the most important conclusions of the research project that evaluated the effect of an intervention based on Motivational Interviewing, implemented in the homes of disadvantaged preschool children.[2]

Beyond having achieved the objectives of the methodology, the project also taught us other lessons. First, it became clear that such home interventions are difficult to implement. Secondly, people are not accustomed to home visits, and dentists and technicians are not qualified to carry them out.

Talking with a Brazilian colleague, who is developing a similar project in his country, we concluded that people in Brazil are much more accustomed to receiving health teams in their homes. It is therefore likely that in cultures more accustomed to home visits, such interventions can have a greater impact, simply because people's attitude is different.

We hope that given the effectiveness of these types of interventions at an international level, and now in Chile, programs of greater scope will be implemented to improve the oral health of the preschool population. Future projects should assess whether the Motivational Interviewing has any impact on the oral health of parents and other family members of these preschoolers.

We think that the opportunity of training and working with dentistry and nursing technicians to carry out home visits is the best option for this kind of interventions at the moment. If you think that they should ideally be dentists, please remember that contents are not important.[1] Therefore, in principle we do not need an expert in oral health. It is well known that working with technicians ensures a greater efficiency in the use of resources, which are always insufficient in public health.

Another aspect that we should evaluate in future projects is the frequency with which the intervention should be reinforced. It is quite unlikely that a single intervention of 4 to 6 sessions can have a permanent effect. As with vaccines, boosters will almost certainly be needed. These boosters should probably be applied or implemented every 1 or 2 years; evaluation is necessary. But since relearning takes less time, 1 or 2 sessions would be enough.

But the use of Motivational Interviewing to improve oral health (actually to prevent it from getting worse) is an incidental issue of this

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project. The truth is that we could (and should) take advantage of these instances to improve skills in health and well-being, to empower people in all aspects of their well-being.

If we later want to mix this more genuine promotional approach with that of collective health, we should think of a system similar to the Cuban one. We could train and work with health technicians who live in the areas where the Motivational Interviewing will be implemented, that is, among their own neighbors. That is empowering not only people, but also empowering communities.

The paradox in health suggests that those who need health services the most are those who have least access to them. On the other hand, those who least need these services are those who access them more easily. Inequity, the Matthew effect, injustice, call it what you want, but let us not sit idly by.

There is also a paradox in the fight against inequity in health. Many of the interventions that are supposed to repair these injustices often end up deepening them. We give people access to dental care vouchers, but co-payment is too high for those who most need dental care. Furthermore, many benefits are informed in written form, but those who most need dental care do not know how to read or simply do not understand what they read.

We want people to improve their living conditions and many times we believe that it only takes a change of mentality, that they should choose to be well, that they should take the plunge and dare to cross towards our side of the road, we are all better here, at the side of well-being. But most disadvantaged people have not chosen to live in such conditions.

To reinforce the idea expressed previously, let us consider an entry from Wikipedia: *In social psychology, the fundamental attribution error (FAE), also known as the correspondence bias or attribution effect, is the claim that in contrast to interpretations of their own behavior, people place undue emphasis on internal characteristics of the agent (character or intention), rather than external factors, in explaining other people's behavior. The effect has been described as "the tendency to believe that what people do reflects who they are"*. (Available at https://en.wikipedia.org/wiki/Fundamental_attribution_error)

Considering all the above, let us remember that we are people who behave as people in front of other people; that we are a deeply unjust society and that there are many elements that perpetuate and worsen this situation. Someone might say that we are almost programmed for inequality.

But our commitment as health professionals should be with the well-being of people, especially with those groups that have historically been deprived of this well-being. First we must be really aware of this situation, to understand its extension and depth. Then we must look for ways to overcome these injustices. As researchers, we must strive to develop, evaluate and validate the best strategies for achieving equity and well-being.

And when we are fulfilling this role as professionals, let us not forget that we are people sharing and interacting with other people.

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