OPINION

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Dental x-roads

by Nigel Knott

What steps can be taken to mitigate the burden that COVID-19 has placed upon dentistry?

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It is difficult to imagine a sector of society where COVID-19 has caused greater havoc than in the everyday practice of dentistry. The dental profession is reeling from a hammer blow that anyone stricken with toothache or dental trauma will appreciate immediately. If a patient is treated in a hospital as an outpatient emergency, then that patient may not notice too much change apart from social distancing being strictly applied. The staff apparel, however, will be of different personal protective equipment in a 'risk ranking' hierarchy.

From the cheery welcome of a nurse or receptionist, the word 'triage' takes on a different meaning altogether. Does this patient require a basic telephone/video consultation (risk level 1), a face-to-face consultation necessitating a basic level of cross-infection control such as a surgical mask and gloves for a dental examination or non-invasive treatment such as a dental impression (risk level 2), or full 'spacesuit' protection for invasive surgical treatment such as tooth extractions or salivary aerosol presence (risk level 3)?

The dental treatment facilities required for the young and the old will come in stark contrast where the very young child and the edentulous senior citizen requiring dentures will usually be classified in the lowest risk outpatient categories (level 2) with consultation/treatment facilities similar to those of the general medical practitioner or the optician of today. It would seem at the outset that level 3 patients will most likely require expensive treatment facilities that will need to be certificated for high risk cross-infection controls more familiar to those found in hospital operating theatres. On economic grounds alone, the practice of dentistry will face a very dramatic culture change and a situation in which the profession will divide into either the role of a physician (risk levels 1–2) or of a surgeon (risk level 3).

This year marks the centenary of the Dentists Act of 1921, when it became necessary to register with the Dental Board (General Dental Council) in order to practise dentistry. About 5,000 formally qualified dental surgeons were joined almost overnight by a further 5,000 dental mechanics, who could register in the light of their technical expertise.

The time has come, therefore, to reflect on the lessons of history and consider the future of dentistry in the light of the dramatic effects of the coronavirus pandemic. What can we learn from the experiences of a profession accustomed to working in everyday general practice within one of the most infected parts of the human body?

From a century ago, the clothing worn by the profession in dental practice has varied from smart attire (morning suits) to less formal, open necked clean white shirts, white coats and now the imminent threat of compulsory 'spacesuits' to protect against the risk of cross-infection. The common principle applied in all clinical dental activities has always been the importance of rigorous handwashing with germicides with or without the use of surgical gloves and masks. Dental surgeries have always needed to be 'clean' but this is a far cry from the conditions necessary to qualify for the 'operating theatre' status today where being 'gloved, gowned and masked' is *de rigueur.*

The treatment of very young children naturally requires special attention to ensure a familiar, friendly approach. How many nightmares have lasted into later life from the traumatic horrors experienced all too frequently in the dental surgery as a child?

The advent of the UK's National Health Service (NHS) in 1948 brought a dramatic increase in the footfall and fortunes of the dental profession with the introduction

of the General Dental Services (GDS). NHS Dental Contract, generous fees and the removal of any financial barriers to patient treatment guaranteed full appointment books and fat bank balances for the dental profession. However, circumstances changed rapidly as the Exchequer's funding unsurprisingly ran out of control (and money) and within two years, patient charges were introduced for artificial teeth (dentures) and spectacles, in an attempt to limit the insatiable demand. Rumours abounded concerning Rolls-Royce employees being placed on factory overtime to meet the demand from dentists. Progressive cuts in professional fees were introduced to stem the flow of taxpayer-funded treatment.

NHS Dental Contracts have continued to change over the years and it may come as a surprise to learn that they have never actually guaranteed any treatment under 'contract', unlike in general medical practice. The NHS dental service is subcontracted from private practitioners, and dentists are able to pick and choose the patients they are prepared to treat as well as the treatments they provide under the NHS – a thoroughly unsatisfactory state of affairs that ends in a postcode lottery when searching for NHS Contract dental treatment.

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We have reached a watershed in dentistry and a decision has to be made on which way to turn at the crossroads created by COVID-19. The choice is clear as the economic cost of providing outpatient dentistry in general practice will become prohibitive if hospital operating theatre conditions become obligatory. The use of disposable dental supplies has already been responsible for significant dental fee inflation and the additional financial burden of COVID-19 will be the last straw that makes dentistry unaffordable for all but the wealthiest in society. This will put the practice of dentistry back in the dark ages.

Solving the dental conundrum

COVID-19 is not the only pandemic we have to cope with today – dental decay is another. The former inflicts immediate fear and dread while the latter inflicts insidious but no less damaging potential for dental disease such as oral cancer passing almost unnoticed.

The mouth is an important signal box and a place in which to detect the early warning signs of a variety of medical conditions and impending illness. We know from history that the NHS cannot provide a dental 'free for all' and a free service has to be limited or rationed. NHS preventive dentistry has long been ignored.

It seems that the best place to continue with what may be considered to be a phase in a dental metamorphosis is in paediatric dentistry, where there is a worrying and unacceptable increase in dental decay and a record number of young children having to undergo dental extractions in hospital under general anaesthesia. Seen in children all too frequently, this common disease is often the precursor of obesity, a condition that will inevitably lead to illness in the form of diabetes later on in life. However, in contrast to COVID-19, while the signs of illness are gradual and apparently unimportant, we ignore them at our peril. The ongoing treatment costs to the NHS will prove intolerable.

As routine conservative dentistry becomes ever more expensive to provide, so the time has come for the government to take drastic action and focus on prevention. The dental profession itself would welcome some form of guaranteed NHS income in these difficult times to cushion the blow of COVID-19.

An NHS dental passport for children

From time to time (every 3 or 5 years), studies are carried out to record a snapshot of the dental health of children. The data themselves are far from encouraging, being unreliable and out of date. No dynamic archive is kept of the state of children's teeth in the UK even in this age of information technology. The daily headlines feature the subjects of obesity and COVID-19. The time for radical change is long overdue.

Every child is born dentally fit. An NHS dental passport for children[1] activated at birth would give the child a conditional guarantee of dental fitness for 18 years. Dental examination, nutritional advice and a weight recording would be key ingredients provided at intervals of four months. Perhaps blood pictures and urine testing might even be included? The dental practice should be remunerated for maintaining the dental fitness levels of contracted patients. NHS payments for the treatment of dental negligence would cease. The health dividend in later years would bring incalculable benefits to the NHS and the burgeoning costs of treating illness would be reduced significantly. This is a precious opportunity for the NHS to create a valuable Oral Health Dividend that really would be the envy of the world!

Reference

1. Knott N. A dental passport for children. *FDJ* 2016; **7:** 104–107.