BAOS
BRITISH ASSOCIATION OF ORAL SURGEONS
Promoting excellence in Oral Surgery through education, training and research for better patient care

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BAOS Feature

Dental Access and Defensive Dentistry

Access to dental services is a topic of concern for every dental professional at the present time, and as oral surgeons we often see the consequences of poor dental access. A recent paper in the BDJ looked at 18 week wait data from NHS England. The authors found that 91.5% of patients were seen and started treatment within 18 weeks in February 2016. Ever since then, this figure has reduced, hitting a (pre-pandemic) low of 79.3% in September 2019. We all know what happened in March 2020, and since this time data has shown that Oral Surgery was the worst performing surgical specialty throughout most of the latter part of 2020, where this data set ends.[1] Recent reports by Healthwatch describe the issue of dental access and how this is increasing health inequalities.[2]

We must also consider the impact of these access issues on a human level. A patient of mine recently travelled from Derbyshire to London for extraction of a painful abscessed third molar as the local services were so stretched that they could not see her for several weeks even on a private basis. We also heard of a patient with haemophilia – so desperate for care that he attended an urgent dental care centre for treatment neglecting to tell the staff of his condition in order to have his tooth extracted on the day. Of course, we learned of this later on when the inevitable occurred. This patient knew the risks and was willing to take these to alleviate his acute pain.

A recent article in the Guardian[3] describes the very personal and moving experience of the journalist Karen Levy as she describes her tortuous route to accessing the care she needed before and during the pandemic. Her main point that is that 'Fear of litigation sees dentists offering patients minimal (or no) treatment when they cannot 'justify' the need'. This issue of 'defensive dentistry' is causing real harm to patients. The extent of this is hard to quantify, however reading Karen's eloquent story is heart-breaking. A recent paper I was co-author on described this fear of litigation as part of the problem when dealing with patient safety incidents in dentistry. We found that some dentists were reluctant to report patient safety incidents due to the concerns about punitive actions taken by regulators and loss of professional respect and reputation.[4] This culture encourages the practice of defensive dentistry, and this needs to change.

Dental professionals are familiar with the fact that dental problems can lead to other health problems and vice a versa. However, the public and some medical professionals are not as conscious of this. With the increase in life expectancy and number of people living with chronic conditions, the knowledge and skill required to manage patients has increased. The only way to learn to treat such patients is to see and treat many of them – but in this era of defensive dentistry, how will this experience be gained? Furthermore, through introducing Tier 2 services and the like, are we encouraging an increase in referrals and a de-skilling of the GDP workforce? At a recent course, one of the delegates told me that she works as a GDP in a practice with an IMOS contract – her referrals to her IMOS colleagues are encouraged and curiously never rejected! Do we have a de-skilled workforce dealing with an increasingly complex patient population?

How do we address these issues? More dentists? In some universities the student numbers have increased, but is there any way to encourage these new dentists to work as NHS GDPs when some of the alternatives are so attractive and lucrative, and the contracts in the NHS so difficult to work with? Why take the risk of removing a molar when it might fracture then face the subsequent struggle to remove the roots often without adequate equipment or training when someone else can do it? The system is creaking under the weight of need at every level – GDP access to IMOS to secondary care and there doesn't seem to be much of an end in sight.

So, we really are facing a crisis on several fronts. What direction is NHS dentistry heading? Who knows, or rather who will say? The Urgent Dental Care Centres created during the pandemic appear to be here to stay and maybe an 'emergency only' patch up type of service is all the NHS will offer in the future with comprehensive care passed over to the private sector, which has always bolstered up publicly funded dentistry anyway.

References:

[1] Ehsan, O. Oral surgery wait times in NHS secondary dental care in England: a five-year review. *Br Dent J* (2022).

[2] https://www.healthwatch.co.uk/blog/2021-12-12/recovery-nhs-dental-care-too-slow-help-thousands-left-pain - accessed 30.5.22

[3]https://www.theguardian.com/lifeandstyle/2022/apr/20/dentists-would-not-treat-my-toothache-now-my-health-has-been-wrecked-for-ever - accessed 30.5.22

[4] Chohan, P., Renton, T., Wong, J. *et al.* Patient safety in dentistry - the bigger picture. *Br Dent J* **232,** 460–469 (2022).

Ed Bailey

BAOS Council Member

Spotlight

An Ode to Surgeons – Gone and to Come

The father of surgery is rooted in ancient Indian medicine. The Sanskrit text Sushruta-samhita, written around 700 BCE by a surgeon Sushruta, describes a classic procedure: reconstruction of mutilated noses using tissue from the cheek.

Surgery has always been considered an art and a science, and surgical advances in war are better understood through the works of pioneers such as Harold Gillies.

A book, “The Facemaker: One Surgeon's Battle to Mend the Disfigured Soldiers of World War” by Lindsey Fitzharris reminded me of the debt to Surgery including Oral Surgery that is owed to Harold Gillies who pioneered reconstructive facial surgery. From New Zealand but educated at Cambridge, he became interested in the nascent field of reconstruction on seeing the injured on the war front.

Returning to Britain, he established one of the world's first hospitals dedicated to facial reconstruction in Sidcup, south-east England. Gillies assembled a unique group of doctors, dentists, nurses and artists tasked with recreating what had been torn apart. When losing a face made a monster to a society intolerant of disfigurement, Gillies restored not just the faces of the wounded but also their spirits.

Ahead of his time and open to multi-disciplinary working, he saw how dental surgeons dealt with jaw injuries and invited them to join his team creating the fledgling specialities of plastic and oral surgery.

His sixteen principles are relevant today and applicable to surgeons in all fields. On such shoulders does the future surgeon rest to create remarkable progress in the field of surgery.

Divya Keshani

BAOS Council Member

Levelling up??

I think we can all agree that 'spreading opportunities and improving public services, especially in those places where they are weakest' [1] is a good idea!
The pandemic has put NHS services in the spotlight. We need to work better, not necessarily harder. We need more transparency that will lead to better value for money for the public. BAOS has many fingers in many pies and we are working hard to achieve the aforementioned position.
Importantly, we are looking into the distribution of oral surgery services in England and as more training posts are becoming available, we welcome the opportunity to ensure fair distribution to try and reach areas where there is a dearth of oral surgery training and, subsequently, services.
We are also looking into NHS coding which the GIRFT report [2] highlighted has many issues. We have uncovered even more issues whilst investigating how we might be able to right the wrongs of the current system.....
Additionally, further analysis and breakdown of the GIRFT report has also led to the creation of a working group involved with trying to improve access to, as well as training for, increased sedation services for provision of oral surgery.
Finally, we have representation in developing new guidelines led by RCS (Eng) for future management of the frail patient.
Be assured, we are taking every opportunity to 'level up' our specialty in terms of recognition, training and value afforded oral surgeons, current and future. Stay engaged, watch this space.

Julie Burke

BAOS President

References

[1] Levellingup.campaign.gov.uk/

[2] https://www.gettingitrightfirsttime.co.uk/medical-specialties/hospital-dentistry/