COMMENT

Letters to the editor

Send your letters to the Editor, *British Dental Journal*, 64 Wimpole Street, London, W1G 8YS. Email bdj@bda.org.
Priority will be given to letters less than 500 words long. Authors must sign the letter, which may be edited for reasons of space.

Coronavirus

IV treatment increase?

Sir, rapid adaption of dental care due to the pandemic includes the delivery of intravenous sedation (IVS) through Midazolam. While the IVS procedure itself, which includes venous cannulation, is not considered an aerosol generating procedure, the turnover rate of sessions has been reduced due to the lack of clinical staff, surgery availability and optimising patient safety.

An audit within our tier two community dental trust in North West England showed a 62.5% drop in the number of IVS sessions in 2020 compared to 2019. While the most notable reason is likely due to the decrease in clinical activity during the initial national lockdown, another possibility is clinicians undertaking more dental treatment during a single IVS session to reduce multiple visits.

The height of the pandemic reduced the capacity for elective activity including dental treatment under general anaesthetic (GA). This increased pressure for patients who may not have been 'ideal' candidates for IVS to review this option. As the pandemic continues and with capacity for elective GA remaining low, community dental services are likely to experience sustained pressure from long waiting lists for this treatment. This may lead to an increased number of referrals to tertiary care for anaesthetist-led sedation or scope to increase the access and provision of IVS in community. In general, IVS may be considered to pose fewer overall complications and mortality rates in comparison to a GA procedure.[1]

Understandably, there remains a cohort of patients where IVS will remain poorly tolerated, with GA being the only alternative. This includes patients with profound autism with heightened sensory function, who would be able to tolerate disinhibition for dental treatment. However, a push and tolerance for IVS playing a more prominent role in dentistry could be more favourable. IVS sessions have allowed a conservative, pragmatic and holistic approach to clinical treatment. As the long-term effects of COVID-19 are unknown, particularly in relation to the respiratory system, it would be interesting to consider the impacts of this on the delivery of conscious sedation in the years to come.

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Reference

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Oral health

Multimorbidity

Sir, I read with great pleasure Drs Watt and Serban's recent opinion paper in the *BDJ*, entitled *Multimorbidity: a challenge and opportunity for the dental profession*.[1]

I fully agree with the authors' sentiments that recognition of the 'multimorbidity' concept will advance efforts to integrate oral health within overall health and wellbeing and ultimately be of benefit to our patients. All through the article they highlight numerous specific benefits, including how this concept will contribute to a more patient-centred approach to patients.

As mentioned in one of the earliest articles comparing patient-centred and person-focused, or person-centred, approaches to care, patient-centred care '[g]enerally views comorbidity as a number of chronic diseases', while person-focused care '[o]ften considers morbidity as combinations of types of illnesses (multimorbidity).'[2] Although there are great overlaps, patient-centred care is disease focused while person-centred care is focused on a person with diseases.[3] This is an important distinction that further enhances the authors' call for oral healthcare professionals to embrace the concept of multimorbidity.

I want to congratulate Drs Watt and Serban for bringing the notion of multimorbidity to our attention, and I hope we will take to heart their rationale for including this concept in our efforts to provide safer, better and more appropriate patient care.

M. Glick, Buffalo, New York, USA

Drs Richard Watt and Stefan Serban respond: As the authors of the multimorbidity opinion piece, we would like to thank Dr Glick for his very supportive and constructive comments on our paper. Dr Glick raises an interesting point in relation to patient versus person-centred approaches to dental care. We were not familiar with the subtle but important differences between patient and person-centred care. We certainly agree with Dr Glick's view that person-centred care which focuses on a person with multiple diseases is preferrable to a disease-focused approach. As highlighted in our paper, multimorbidity is becoming a major priority for service development and research which will require innovative and collaborative approaches including ensuring that people with experience of living with multiple conditions are involved in all stages of development from design to dissemination.

References

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2. Starfield B. Is patient-centered care the same as person-focused care? *Perm J* 2011; **15:** 63-69.
3. Eklund J H, Holmström I K, Kumlin T *et al.* 'Same same or different?' A review of reviews of person-centered and patient-centered care. *Patient Educ Couns* 2019; **102:** 3-11.

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