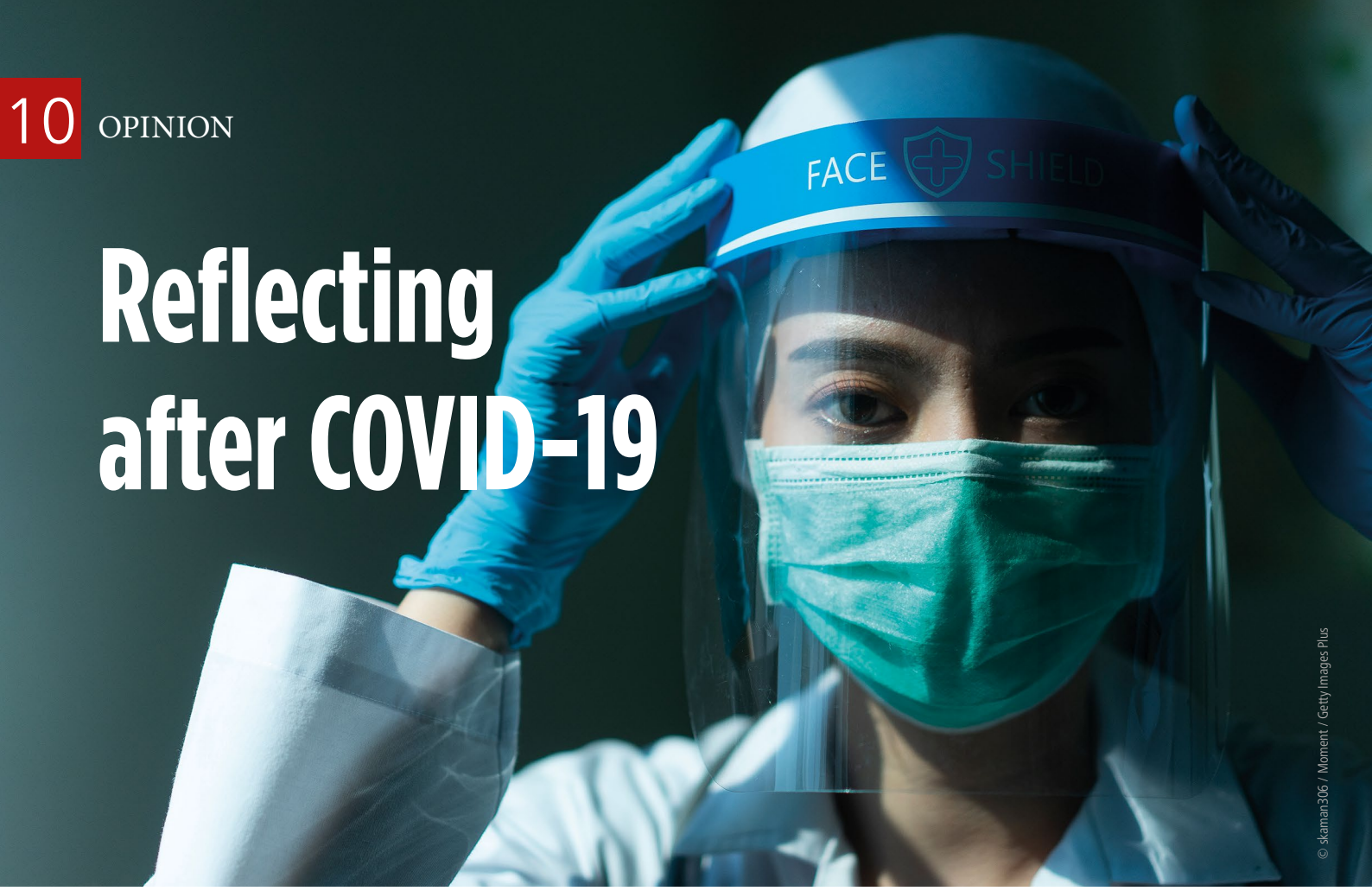
Reflecting after COVID-19



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Reflection was introduced by the GDC in 2019 as part of their enhanced CPD requirement. The process of reflection is intended to foster improvements in the service provided to patients. It also serves to demonstrate that you have listened and acted on patient feedback and complaints, as well as assuring patients that your dental team is prepared to learn from experience.

Good things from bad

The modifications that were required to the way in which dentists could work during the COVID pandemic certainly provided the dental team with additional downtime to reflect on what had worked well in the past twelve months and what things could be done differently in the future. There is a certain irony in the fact that a highly communicable disease like COVID-19 could improve things for the dental profession in its battle with non-communicable conditions such as caries and periodontal disease. Even more ironic is the fact that science has yet to eradicate either of these long-standing diseases but has developed a control for a novel corona virus in under a year. But then, allocating funds to benefit the health of the nation is a political decision and requires a different approach.

Digital migration

The opportunity for reflection during the pandemic was made all the more stimulating by the explosion of online webinars and courses that were available to stream at convenient times in your own home and often at no cost. This development looks likely to be a regular joining option for future postgraduate meetings and conferences.

If you have taken the time to reflect on a particular aspect of clinical practice and think it could be improved, it is only a 'short walk' to change your point of view before modifying the way that you work. Converting thoughts into actions may not seem particularly complicated or difficult to an external observer, but the task can sometimes seem insurmountable to the individual clinician who is faced with making the changes. It is a matter of perception.

Accepting change

If you can accept that it would be logical (and also beneficial) to change a particular aspect of your behaviour, hopefully there will be a matching desire to adopt a scientific approach – and modify your protocols in the light of reliable new information.

Beyond any personal inclinations to make changes, there may be other driving forces which influence the rate at which change happens; the speed being commensurate with the authority of the source and any penalty for not so doing.

Instead of initiating a hurried episode of review in an attempt to catch up, it would seem more sensible to reflect on our own practise of dentistry from time to time, to see how it measures up to the latest information disseminated from these different sources (of varying authority and attraction).

Doing no harm is a required ethical commitment for every medical professional. But even if every clinician does their very best work when treating patients there will always be a spectrum of different outcomes because of the many variables involved. The prevailing spectrum of acceptable standards will reflect the local availability of materials, equipment and training, but in general terms those standards improve with time.

The risk of doing nothing

The evidence base in dentistry continues to grow and has never been more accessible. Indeed, it could be argued that a failure to keep abreast with the latest developments could result in sub-optimal treatment. If that resulted in avoidable damage to the patient, not only would there be a breach the fundamental ethical concept of 'do no harm',

but it could possibly be viewed as clinical negligence by omission.

By adopting a reflective approach to the practise of dentistry you can avoid such an accusation. Indeed, most of the profession already do this to a greater or lesser extent. Interestingly, the more often you take the time to review your own understanding of topics, the easier the process becomes. In addition, the level of personal satisfaction derived from your work will increase– and the same will be true for the team around you. To that end, it is desirable to reflect on things that go well, alongside things that don't go to plan.

Lifelong learning is the cornerstone that supports every profession. It is best to carry out a training needs analysis based on clear educational, career or practice objectives. In this way, it becomes possible to select courses that will remedy any skill-gaps and so meet those objectives. The list may well include subjects that do not have the automatic appeal of some others, but which are still necessary in order to fulfil the required objectives.

A dentist has a duty to provide care of an appropriate standard to avoid allegations of negligence. The progressive upward revision of the required standard of treatment to be provided is driven by an evolving evidence base and is also influenced by patients' expectations. As a result, some techniques for delivering dental care have changed dramatically over the past ten years. Obstinately persisting in using outdated techniques contrary to recognised opinions and evidence is both unprofessional and unethical, especially when those techniques have been shown to cause demonstrable harm in the past.

Good for patients and the dental team

Regular reflection on all aspects of our clinical work can result in an improved quality of patient care. This view is shared by the *Editor-in-Chief* of the *BDJ*, Stephen Hancocks, in an editorial that considered some of the beneficial effects that would accrue from the pandemic: *'My prediction is that ultimately the majority of good will come not through system change but through individual reflection and in dentistry that this will be manifest at all levels and through all team members.'*[1]

Others have taken this opportunity to reflect on the dramatic absence of dental treatment that left thousands of patients with cancelled appointments and many in pain. Access was hampered by economic issues and the need to adopt effective and elaborate infection control procedures to prevent the spread of the disease. In the UK this resulted in a backlog of treatments and significant financial challenges for those in the business of dentistry.

International agreement

When there is a shortage of healthcare resources it is logical to distinguish between essential and elective treatments. There is also a role for Government to provide access for urgent essential treatment. But, when it comes to oral healthcare there is, as yet no global consensus on what might reasonably constitute essential treatments.

The United Nations (UN) periodically holds high-level meetings of the General Assembly which provide an opportunity for world leaders and policy makers to publicly declare a consensus of their intentions involving human rights issues and this includes access to healthcare. But it all too easy for policy makers to forget about dentistry. During the latest pandemic it took a while to even establish that dental teams were essential front-line workers and to offer them priority vaccination. It would have been easier if dentists had automatically been recognised along with all the other healthcare workers who provide universal healthcare coverage through the NHS and also privately.

There had been an opportunity to place oral health on the agenda of the high-level meeting on 27 Sept 2018 convened to discuss the global impact of non-communicable diseases, but it did not happen.[2]

A year later there was an opportunity for oral health to be included in the political commitment to strengthen Universal Healthcare Coverage in the high-level resolution adopted by the General Assembly. The wording of Clause 34 does sound like a bit of a catch-all addition, but at least oral health is mentioned: *'Strengthen efforts to address eye health conditions and oral health as well as rare diseases and neglected tropical disease as part of universal health coverage.'*[3]

Defining the cost

By defining 'essential oral healthcare' you create the basis for modelling costs and financing. Reflecting on the recent experience of COVID-19, urgent treatments can be prioritised as a sub-set of those essential treatments. The need for such a practical consensus was picked up by Benzian *et al* in their proposed definition published at the turn of the year.

'First, oral health care must be an integral component of a health care system's essential services, and by implication, oral health care personnel are part of the essential health care workforce.

'Second, not all dental care is essential oral health care, and not all essential care is also urgent, particularly under the specific risk conditions of the pandemic.

'Third, there is a need for criteria, evidence, and consensus-building processes to define which dental interventions are to be included in which category of essential oral health care. All stakeholders, including the research, academic, and clinical communities, as well as professional organisations and civil society, need to tackle this aspect in a concerted effort.'[4]

This is a path we must walk, led by organisations like the BDA. Dentistry must not be an afterthought, and coming out of COVID-19 gives us an opportunity to make that a reality. ◆

Factors promoting change

- → Legislation (eg. Health and Safety)
- → Advisory documents from recognised bodies of opinion (eg NICE)
- → Advice from the BDA and the GDC
- → What other colleagues are doing
- → Advice given during didactic teaching
- → Peer reviewed dental articles
- → Sales pressure from dental supply companies
- → Adequate finances

References

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3. United Nations. Political Declaration of the High-level Meeting on Universal Health Coverage. 2019. Available online at: www.un.org/pga/73/wp-content/uploads/sites/53/2019/07/FINAL-draft-UHC-Political-Declaration.pdf (Accessed April 2021).
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