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

The aftermath

Sir, during this current global crisis, is it not appropriate at this time to ask the question: 'how will COVID-19 impact on future dental care provision?' I feel it is appropriate to raise the topic early so that the dental community can begin to think about the problem and thus devise a strategy to manage the future.

Almost all dental procedures generate aerosols, from the 3-in-1 used during an examination, to the high-speed handpiece and the aspirator. We are all familiar with the concept of 'universal precautions' whereby in the past we have assumed that every individual is a source of potential cross infection, now more so than ever before our current environment exemplifies this.

Whilst we must expect that coronavirus will exist amid the general population of the world for some extended time period, we must by definition assume that the dental profession will need to adopt equally rigorous PPE and procedural policies (pending the progress of COVID-19 testing amongst the populace). This is not only to address any perceived risks from the general public, but also those real threats to patients and staff.

Arguably, should the air-flow of clinical spaces, either generally or in the immediate working area of the mouth, need reviewing? Would the return to treating patients in an upright sitting position reduce the need for aspiration? As a clinician who regularly treats some patients in this sitting position, I am aware of the limitations of some chairs and dental units in adopting this posture, as well as the differences between working with direct and indirect vision, and the postural issues for both operator and nurse. Is the modern dental surgery fit for purpose post COVID-19?

Reports seem to indicate that the current patient throughput of the Urgent Dental Care centres, recently set up to cope with dental emergencies, is around eight patients per day. Even with honing and practice this falls far below the pre-COVID-19 patient throughput figures for even private clinicians. Ultimately, should we not be recognising that the dental profession as a whole will be operating in a very different environment to that which we began the new year of 2020? This not only extends to the UDA re-imbursement system but also to our mode of working.

A. Blake, Devon, UK

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The end of skill mix?

Sir, nothing has so undermined the concept of the team working in high street dentistry so much as the present coronavirus crisis. The perception that the current management of business risk and anxiety is shared between practice owners, dental therapists, hygienists and nurses can now be finally put to rest.

Skill mix was a worthy aspiration. Any notion, however, that it can lead to an equitable sharing of responsibility between team members is now finished. The present closure of practices is difficult for employees, but it is nothing compared to the financial burdens faced by dentists with debt interest on borrowed capital. Unable to demonstrate any activity, NHS practitioners will find it difficult to be prioritised in any promised government handouts.

The notion of a dental team was always fraught. Employing a dental therapist so that a practitioner as a practice owner can carry out more complex procedures is the last thing a NHS provider is looking for. NASDAC are wary of advising clients to employ hygienists in non-mixed practices. Their contribution is only sustainable because of the ambiguities in providers' contracts. This does not apply to therapists in general practice which is the reason why the majority have to work as hygienists. The management and costs of employing dental nurses to carry out fluoride varnish application is not really a viable business model.

Granted that true skill mix, which by definition would require regulatory reform, could improve access. It might also control/or give better value to public expenditure. However, as the present public health crisis demonstrates the term 'skill mix' remains an egalitarian fantasy supported only by salaried academic elites. They know little of the high street.

E. Gordon, Finchley, UK

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Enhanced PPE?

Sir, with routine dentistry within England halted due to the current COVID-19 pandemic and the Chief Dental Officer's limit of providing emergency care only during this time many GDPs now find themselves in a situation whereby they telephone triage patients, providing either analgesic advice or remote prescribe antimicrobials where applicable. Patients with facial swellings, uncontrolled bleeding, dental trauma or other dental emergencies are referred onward to a suitable emergency treatment centre.

A large part of why GDPs are unable to provide treatment is their lack of correct PPE. At present the guidelines regarding correct PPE for treating asymptomatic patients, as well as suspected or positive COVID-19 cases, are unclear. There is debate particularly in regard to the use of