

# SIMON ROGERS: 'ULTIMATELY WE NEED BETTER ACCESS FOR PATIENTS'



There's no escaping the escalating rates of head and neck cancers we've seen over the last decade, and that will inevitably lead to an expansion in the role of the dental professional over time. David Westgarth speaks to **Professor Simon Rogers** at Aintree University Hospital about what it takes to succeed as an oral and maxillofacial surgeon.

## Why maxillofacial surgery?

I really enjoyed the challenges of surgery. I qualified in 1984 from Sheffield University and, at 22 years of age, did not feel ready for dental practice. I got my first job in Newcastle as a house officer in oral surgery and really enjoyed it. By the summer I was a senior house officer on the Freeman, Royal Victoria, General Hospital rotation. I was successful first time in the primary fellowship exam in the autumn of 1985. As I was relatively young I thought what shall I do next, and I was fortunate to get a place at medical school the following year.

I always had an interest in complex surgery and the patient experience. I found it fascinating, particularly the cancer side. When I was 9 months qualified as a dentist, I will always remember I had one patient present who could not stop dribbling as he had his jaw removed due to cancer. It was a challenge to improve his quality of life and also his functionality. Part of me felt the patient shouldn't have had that treatment because he clearly wasn't able to cope, or we should have done better. This was at a time when free flap reconstructive surgery was becoming established and the transformation in outcome offered by these techniques spurred me on to gain experience in this area.

## What kind of character does it take to do this job?

It certainly takes an ability to empathise with the patient and their family. Lots of high-level communication is required in terms of decision-making, treatment planning and helping patients adapt to their 'new self' post treatment. Having done work in general dental practice I know exactly the same set of skills are required. The outcomes may be different, but functional,

## 'Patients should be able to get advice from specialist centres without necessarily being seen by a specialist...'

psychological and social aspects are all important when speaking to a patient about a crown or bridge and their treatment plan.

Head and neck cancer takes those skills to a higher level. It requires a team approach and you have to be able to bring the team together with the patient at the centre.

Working in the head and neck cancer environment is complicated and involves long hours, particularly during surgery. The difference between success and failure can be very stark in terms of functionality, morbidity, psychological distress and survival. You need a certain resilience and inner strength to be able to function at that level week in and week out. With training, experience, and colleague support you somehow find coping mechanisms to get you through extremely difficult situations.

## So do you think empathy can be taught?

We all have different skill sets. Some clinicians are more empathetic than others and some are better communicators. The challenge is to find the best qualities in the team and bring them to the fore. However, in spite of personality differences, yes to varying degrees, empathy can be learnt by clinicians.

## What are your thoughts on the current care pathway for patients?

There's a whole agenda for better information, dialogue and synergy between primary and secondary care. In the old days it used to be a phone call. Systems may be more complex these days but in a way they are simpler to use, such as emails. If we can integrate better technology and an IT framework then it will help to streamline care. Patients should be able to get advice from specialist centres without

necessarily being seen by a specialist, likewise certain patients should be fast tracked into specialist centres depending on what the condition is.

## The theme of a 'team approach' is something you intend to cover at the upcoming BDA Conference, so what are the key points?

One of my biggest priorities as a clinician when looking after oral cancer patients is the importance of the team approach to care for that patient and their carers. General dental practitioners (GDPs) are absolutely vital throughout the process. They're key in raising awareness of head and neck cancers – although I do acknowledge it can be difficult to keep awareness levels high all year round. They are key in diagnosing and referral, and also have a crucial role in the patient's aftercare. Maintaining a head and neck cancer patient's dentition can be very challenging. The GDP is also involved in reassuring the patient about recurrence.

## What can be done about raising awareness of the risk factors and signs and symptoms?

I would call for research across different specialities to find out more about why patients fail to grasp an understanding around the causes and symptoms of oral cancer. Research we carried out shows patients are unaware of the disease and tend to dismiss symptoms as trivial and something that is going to get better, with little or no thought that it could be cancer. It is only after a period of time they do something about it and ultimately present too late.

It also boils down to the fact some patients are inherent risk takers. Mouth cancer is a relatively uncommon disease but symptoms are not.

Patients most at risk do not necessarily have routine dental care or engage within the healthcare system. They are more likely to ignore the symptoms. We need to promote early diagnosis and referral through a multi-faceted approach, such as working with pharmacists.

We conducted a survey in our area looking at access to emergency dental care, and one of the outcomes was that if a patient who didn't have a dentist, called one up and said 'I have pain could I have an appointment?' there was quite a delay in getting it. I think it could be a good idea for dental receptionists to find out more from the patient. They could ask why they have got the pain and provide a triage to differentiate between patients with an ulcer that's lasted three weeks who are heavy smokers and those who have toothache. Ultimately, we need better access for patients.

**So what's your opinion on NICE recommending extending recall periods?**

I can understand the evidence-based approach on risk, intervention and cost; however, there are three concepts I would add as an oral cancer surgeon. I have seen cancers that grow rapidly over a matter of weeks, and some that don't change at all over many weeks. Elongating the recall period runs the risk of something developing quickly and relying on the patient to act, which we know is not always the case.

My second point relates to a previous comment. Patients need to be aware of the symptoms and have access to urgent care when required. When a cancer patient has been through the cancer journey once, you will find they are much more likely to pick up the phone and make an appointment if symptoms aren't getting better after a week or so.

Finally, we need a policy that is stratified and accounts for the individual. A 20-year-old female, non-smoker, non-drinker who regularly attends appointments doesn't need the same intensity of review as someone who fits a higher risk profile, eg older, life-long smoker, social inequality. However, one has to acknowledge that oral cancer does occur in patients with no obvious risk factors too.

**Does access to urgent care require a more integrated approach?**

**'You have to be able to bring the team together with the patient at the centre when dealing with cancer'**

For oral cancer in our department, around 30% of patients come through GDPs. They come with quicker and more accurate diagnoses too. In many ways the dentist is better at diagnosing premalignant lesions and cancer than the general medical practitioner as they have a better skillset.

A closer partnership between the pharmacist and dentist would be helpful. If someone comes into the pharmacist with a history of an oral ulcer which has been present for three weeks or more that should set off warning bells. One has to be careful not to overburden other healthcare providers with information, but, for example, smoking cessation and alcohol reduction groups should talk about risk factors for oral cancer. Social workers, practice nurses and community nurses need to be aware of symptoms so if there's any mention by the patient suggestive of those symptoms they recommend an urgent referral.

**How does head and neck cancer affect the patient's family?**

Family support is absolutely critical, and it should start at time of diagnosis and when discussing treatment options. Whatever the patient might think, family support is critical to recovery. To get through oral cancer surgery, chemotherapy and radiotherapy is nearly impossible by yourself. We need to be much more effective in recognising and addressing patients' concerns. This has led to the development of the Patients Concerns Inventory and its use in routine practice.

Evidence suggests a functioning family supporting in the right way substantially helps a patient's recovery. If the carer finds the burden too much and is struggling, that struggle is mirrored by the patient. There is relatively little specific research into this area because head and neck cancer is a rare condition.

**Do you think head and neck cancer patients should pay for routine dental check-ups?**

No. Consider the number of head and neck cancer patients diagnosed every year, the number who are long-term survivors, and the difficulties of treating these patients who can require advanced restorative work. They require more frequent access to dental care; so I believe it should be free.

**Has the rise in HPV-related cases meant that you are seeing patients getting younger? If so, what will this mean for future treatment plans and approaches?**

Unfortunately, HPV means that the age profile of head and neck cancer is getting younger. The difference is these patients can be regular dental attenders and do not conform to traditional risk factors.

**What approach can you take when there are no traditional risk factors?**

Patients often want to know about the cause. It's often the first thing they ask. Unfortunately, more frequently we are now seeing patients without obvious risk factors. Not only are we seeing both younger patients due to HPV, we are seeing older patients as society lives longer. Older patients are less demanding in terms of expectations *versus* reality of outcomes and the impact on their quality of life. We are doing radical surgery on 70-85-year-olds, and we can still perform radical surgery with the intent to cure.

**With all these changes afoot, how will Aintree keep ahead of the curve?**

We are looking across the patient experience and carefully assessing treatment and outcomes. Ultimately we are always trying to improve survival figures. We are trying to maintain our high cure rates so that functional and quality of life outcomes are better. At Aintree we have a close collaboration with patients through the Patient and Carer Research Forum, researchers expert in molecular oncology, clinical trials, public health and patient experience, and the multiprofessional team. This synergy and partnership is what drives future progress in the management of oral cancer.

Simon Rogers will be speaking at the British Dental Conference & Exhibition 2016 in Manchester on Thursday 26 May. Simon's talk will be on the topic of 'How the general dental practice team can improve outcomes for oral cancer patients.' Register online at [www.bda.org/conference](http://www.bda.org/conference). Three-day conference passes are free to all Expert, Extra and Senior BDA members and these free passes can be booked through the website.