

COVID-19 a personal reflection

Over the last few days, each time I decided on a subject for this editorial and began writing, my chosen themes soon seemed insignificant amid this growing global health crisis. But I hope that within my reflections I will resonate with the spirit of what we are living through in these extraordinary times.

My role as an academic and clinical consultant in special care dentistry and medically compromised patients at Trinity College, Dublin has meant that I was one of the lucky few within the dental profession who retained a salary. Nevertheless the pandemic immediately and completely disrupted the way in which we go about our daily work, with immediate loss of boundaries, working hours, roles, and responsibilities. Like many other key health and social care workers carrying out risk procedures at these times, I have chosen to live alone. However, I have gained great comfort in being able to offer financial and emotional support to members of my family who have progressively lost their incomes.

Necessity is the mother of invention, and the past months have been a particularly fertile time for creativity. Trying to find innovative ways to teach and assess our clinical doctorate students online from their homes spread all over the world has been challenging. I have always advocated for experiential learning and exposure to disability with mentored guidance in *SCD*, rather than rote book learning. However, now is the perfect time to bring meaning to their knowledge. An opportunity to affirm the benefits of minimal intervention techniques while utilizing new COVID-19 inspired vocabulary such as aerosol generating procedures. Time to focus on social determinants of health and ask big ethical questions or to provide moral dilemmas, all aiming to produce health care professional who will be competent to innovate, advocate, adapt, and respond to the changing needs and demographics of our patient populations.

Any illusion of being able to take research time at home to explore data from recent studies, write up long-awaited papers, or write new research grants has been quickly put to bed. In snippets of free time, I am still finding it hard to concentrate or focus—maybe you have noticed that, too? In the face of this emergency, I am mindful of how little words matter compared with actions.

In Ireland as we planned for lockdown in the department, our team worked hard to ensure that emergency triage

would be inclusive and accessible for people with disabilities and disadvantages, including prisoners. We initiated the use of tele-dentistry and obtained home access to our electronic records and enabled remote prescribing. All those things that we had been dreaming of doing for years and marvelled at how fast the pandemic had made the previously impossible or unworkable possible, in a matter of a few days.

After a quiet first week, the patients started to come. Many came with complex medical conditions breaking curfew and expressing great shame at not being able to cope with pain that had left them unable to function. Others who felt guilt for having knowingly neglected their dental health, worried that they would unknowingly infect us or their loved ones by coming into the hospital, despite our assurances to the contrary: yet another burden of poor oral health to add to the list. Thomas McKeown, author of “The Role of Medicine: Dream, Mirage or Nemesis?” wrote that “if he were St Peter admitting to heaven on basis of achievement on earth he would accept on proof of identity the surgeons, the dentists and with a few doubts the obstetricians.” I have always been amused by this but of course our strength is most evident at these times. We can perform procedures and treatments that can often instantly stop the source of great pain. However, now 7 weeks into total lockdown, we have rarely heard or seen our patients with intellectual or developmental disabilities who usually make up at least half of our case-mix. I am certain it is not because they are NOT experiencing dental pain: their oral health was always the most challenging to maintain. I can hardly bear to think about how they and their caregivers must be struggling to manage their lives with all the additional challenges their conditions superimpose on lockdown. However, I am also ashamed to say that I am also sometimes almost relieved that they are not in touch as we have little chance of accessing anaesthetic services to manage those with the most care-resistant behaviors at this time in our hospitals. I wonder what we will find once we lift the lid on what lies beneath their notable absence.

I have continued to provide necessary dental services to the oncology and bone marrow transplant units as they continue to deliver lifesaving therapies during this crisis. I had assumed that people who were profoundly immune

compromised would be especially fearful of attending. However, it seems to the contrary that they have watched with interest as the rest of the world adopted the social distancing and infection precautions that they are so familiar with. “Welcome to my world” one woman joked “I hold a masters in social distancing and nowadays there’s better daytime television, I can visit virtual galleries for free, attend lectures, go to church and even have my dental consultation from the comfort of my own home.”

I have since read elsewhere that people with a range of other disabilities have described this lengthy period of lockdown as having similarly enriched their lives. But have found it rather infuriating to hear people moaning about their own restricted access and enforced isolation that many people with disabilities already endure on a daily basis. Perhaps some also feeling somewhat betrayed to see that remote working and studying had been possible the whole time now able-bodied people required it.

Like many dentists I have been repurposed for part of the week. For me this means additional roles working as a phlebotomist and also once a week as “swabber”: part of the testing and tracking team from all areas of health and social care as part of Ireland’s strategy to reduce spread and monitor infectivity. Working among people with a mix of skills and experiences there is much talk about COVID-19 crisis being a great leveller, but of course it is quite the reverse. Pandemics always expose vulnerability. While we may all be in the same storm we are not in the same boat: it is terribly difficult to stay at home, when you are homeless. It is also difficult not to touch multiple surfaces during the day when you are visually impaired and need to use touch to navigate the environment.

During the 2009 H1N1 influenza pandemic in the United States, individuals with poorer health outcomes were those in the lowest socioeconomic groups and those with inadequate housing. Inequality is again being laid bare during these times via the evident failure of health systems to meet even the basic care needs of older people, thereby exposing the most frail and those in nursing homes to unnecessary risk. The public have seen first-hand the frank ageism in the attitudes and language being used in the media toward older people, often portrayed as a homogeneous vulnerable group, the inevitable victims of COVID-19. In this regard, I have been most uncomfortable to imagine the impact on the self-esteem of content; fit and healthy older people seeing their peers applauded as heroes when they publicly give up their rights to hospital care in order to free up space for those supposedly more deserving by virtue of age.

Less visible are the attitudes toward those with intellectual and developmental disabilities (IDD). Recent reports suggest that people with IDD are dying from coronavirus (COVID-19) at startling rates, due in part to the inherent risks of under-

lying medical conditions and behavioral impacts that make social distancing and hand washing almost impossible. Also undoubtedly due to the slow pace at which the disability service structure has responded to the pandemic. We have seen pressure from families and patient organizations demanding reasonable adjustments to lockdown arrangements to account for challenges in managing behaviors, exacerbated by a total disruption of environment, routine and familiar caregivers. We have also seen legal challenges to assure the equal rights of people with disabilities to receive life-sustaining treatment. There has been an urgent need to alert medical personnel to the risk of applying inherent bias denying or rationing medical care on the basis of stereotypes, assessments of quality of life, or judgments about a person’s relative “worth” based on the presence or absence of disabilities. We will probably never know the extent of how this pandemic has impacted on death rates of people with IDD as it so often remains custom and practice to cite the underlying condition or syndrome on a death certificate. Furthermore, many of this population may have died in a community setting rather than hospital so their statistics may be excluded from the final tally.

Looking to the future, Immanuel Kant a critique of pure reason said we can reduce all questions to three: What can I know? What should I do? What dare I hope?

Currently, the science and knowledge we can glean from multiple sources is changing almost daily and may change by next month...or in this instance, an hour from now. We are very familiar with occupational health issues and risk assessment in dentistry, whereas many other professions do not have to consider such issues until now. The *New York Times* reminded the world that dentistry had the most risk of any profession in relation to COVID-19. Dental teams will no doubt evolve a system that will balance risk with practicality and affordability and availability as we live beside this virus while awaiting a vaccine or a reliable antibody test. Each time I tie my surgical mask over my FFP3 mask each day I am reminded of the previous fashion for double gloving in the days gone by when HIV changed the way we practiced for ever back in the 1980s.

What I plan to do is to work hard to retain the best of the special measures that we have put in place to overcome the physical barriers disabled people face and able-bodied people appreciated to retain a more permanent accessibility and improve oral health. Tele-dentistry and accessible learning are to name but a few. It is also time to harness the power of the interdisciplinary team and the patient organizations to advocate and work together to ensure that no one is left behind as services are rebuilt and reconfigured in the communities.

Finally, I can hope that in our rush to protect ourselves, we do not succumb to commercial pressures to unnecessarily

overburden the planet with unnecessary plastic and disposable instruments or pump noxious chemicals into our working environment as a knee-jerk reaction. The quality of our air is something that I hope becomes a priority going forward.

What will remain unknown for some time is how countries will value their health services when this pandemic has passed? How will essential services be acknowledged and funded in the future? Has this pandemic helped to build trust or resentment towards those in power?

How we answer these questions will no doubt have profound effects for generations....



Alison Dougall
Chair of the International Association
for Disability & Oral Health (iADH)