Performing Dentistry
Neel Kothari discusses UDAs and Associates

It is my contention that dental associates have suffered the most following the 2006 overhaul of the NHS dental system. Far from being the beacon of the self employed world in full control of what goes into the patient’s mouth at the point of delivery, dental associates are now more commonly finding themselves tensely close to the definition of an employee, being told how many points are needed to be collected every month, the value of each point irrespective of how hard it is to achieve it and increasingly what work they can and cannot carry out on the NHS.

The official term ‘perform’ clearly does not do justice to the complex and intricate relationship between a dentist (or any healthcare professional) and their patients. Whilst technically associates are ‘performing’ a service, this service is almost impossible to perform to best practice guidelines within the auspices of only three bands. Whilst a label is just a label, I am concerned that the respect of associates within the profession is slowly disintegrating. Labels have an emotional attachment for many people, so as a profession what does it mean to us if we are no longer creating new and unique relationships between dentists and their patients?

In a recent job advert placed online by an unnamed corporate group, the position was for an associate GDP to ‘perform’ 8,015 UDAs for a ‘competitive’ salary and a 50 per cent contribution for lab fees. Sounds pleasant, but how will this work? If we assume that one takes six weeks off work for holidays and one week for CPD, this works out 58.5 UDAs per day needing to be achieved for the target to be met. I’m sure some will think ‘fine’, whilst others may frown, however one thing that I really can’t figure out is how on earth this relates to clinical need. Can one really carry out 8,015 UDAs a year without knowing how much actual dentistry is needed to meet their allocation or does this simply place an unfair and perverse incentive on the dentist in order to ‘perform’ their associate agreement?

Let’s not forget that many of these UDAs will often include ‘new patients’, who could require a ridiculous amount of work in order to achieve three or 12 UDAs. What sort of incentive does this place on associates aiming to meet their UDA allocations: large fillings or gold onlays? Treat all cavities or watch some? Available on the NHS or Private only? Root canal therapy or extraction? Of course as a mere dentist, I dare not suggest that clinical decisions are being affected by financial incentives rather than the patient’s best interest. Thankfully the Health Select Committee did that for me (2nd July 2008).

Along with completely irrelevant UDA targets with little sensible link to treatment need, dental
associates all too frequently are placed in a very difficult position, whereby in order to get a job they have to accept UDA targets not really designed for them, levels of remuneration based on the realities of supply and demand rather than clinical need and the full liability of clinical decision making should something go wrong. This cocktail of ingredients may work for the architects of the nGDS contract, but surely there must be a trade off in front line services and the professional integrity of those dentists who are often placed in this position.

Whilst many within the industry may complain of how they have been affected, I personally feel that the worst affected are dental associates, especially those just entering into the profession. The complexity of providing quality NHS dental services seems to be traded off in a system designed to make professionals meet targets and score points based on formulas designed by a series of accountants rather than focusing on quality dental care.

Over the past few years I have had many conversations with colleagues on the basis of ‘what do you provide on the NHS?’ The availability of NHS provision is not really a postcode lottery but probably more a case of how the dentist interprets the 2006 contract and what funding they have in place. Whilst the vast majority of dentists are most likely in agreement over what constitutes standard treatment, we come back to the age old question of ‘what exactly should be available on the NHS.’ The standard DH answer to this question is whatever is clinically necessary. In some cases ‘clinically necessary’ ranges from a full acrylic denture to an all on four implant supported bridge!

Now corporate organisations may not like this next bit, but oh well.

The ability to use the youngest members of our profession in an attempt to meet a ridiculous number of points for a fee scale designed to encourage a swing away from best practice is unfair, untried and untested. It deliberately abuses the self employed nature of an associate and their ability to retain control, whilst at the same time heavily promoting business agendas which are not always in the patient’s best interest. This dilutes professional integrity in a worse way than when Mercedes Benz released their A class (original design not the latest version which starts on the road from £18,945).

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About the author
Neel Kothari qualified as a dentist from Bristol University Dental School in 2005, and currently works in Sawston, Cambridge as a principal dentist at High Street Dental Practice. He has completed a year-long postgraduate certificate in implantology and is currently undertaking the Diploma in Implantology at UCL Eastman Dental Institute.

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