Oral Surgery in Thailand: The WHO Checklist and Consent

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In July 2016 we travelled to Mae Sot in Thailand to complete our elective project. We both had an interest to travel to South East Asia and observe how dentistry is provided in rural Thailand. As oral surgery is our favourite rotation the aim of our elective was to assess the use of the World Health Organisation (WHO) Surgical Safety checklist and to observe how consent is obtained prior to dental extractions in patients in Mae Tao Dental Hospital, Thailand.

Staff at the Oral and Dental Health Care Clinic, Mae Tao Community Hospital

During our two week placement at Mae Tao Clinic, we observed two qualified dentists and five individuals who had not received formal training perform procedures that are undertaken on a daily basis in Bristol Dental Hospital. Whilst our project was centred on Adult Oral Surgery we also observed patients receiving direct composite restorations, root surface debridement and several paediatric extractions.

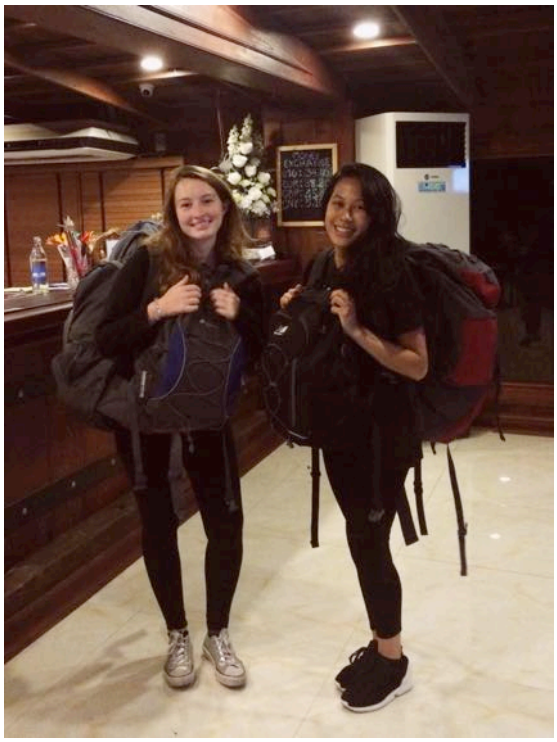
Throughout our time in Mae Tao we recorded our observations by both keeping individual daily diaries and completing a checklist. We attended the dental clinic between the hours of 9am-1pm over a period of two weeks. For the duration of our study at Mae Tao Clinic we observed a cohort of seventy patients, fifty of whom underwent adult extractions. Due to the nature of the clinic, catering primarily to Burmese refugees, the majority of the patients seen were 'walk-ins'. With this in mind, the influx of patients was unpredictable and varied greatly on a daily basis. All patient notes kept by the clinic were documented in English. Consultations were brief and patients' medical histories were not reviewed. Radiographs were not considered a pre-extraction necessity. Three treatments were available at the clinic: composite restorations, extractions and a sub-gingival scale. The limited treatment options were dictated by lack of formal clinical training and an absence of funding from the government.

An unconventional check-up!

Consent forms were not part of the clinic's practice. Although consent forms do not prove informed consent, it does act as a record of the consent process and that discussions of the treatment have taken place. Implied consent raised the question whether the patient had fully understood the information and the issue of incomplete information given. The clinicians were quick to assume the patients understood, unless they refused. In these cases and with all patients, a dentist should take steps to ensure the patient gets and has understood the information.

There was no protocol for extractions in Mae Tao to reduce the risk of wrong tooth extraction. In BDH, the WHO checklist involves the dentist and nurse, and it is of vital

importance the checklist is completed efficiently and effectively. The preceding extractions are also written on a whiteboard and on the patient's bib. However, in Mae Tao Clinic no effective actions to try and improve patient safety during extractions were observed.



Before the long flight home

In conclusion, the extraction protocol and procedure carried out by clinicians in Mae Tao Clinic were very different to those employed in Bristol Dental Hospital. In Bristol patients are given a full explanation of the procedure and the associated risks and benefits. Patients are expected to make an informed decision and consent is obtained verbally or written. In the UK, the General Dental Council dictates standards that all dentists should adhere to and, consequently, ensures that valid, informed consent is obtained before every treatment. Due to the nature of the service provided by Mae Tao Clinic, communication can be a struggle and therefore valid consent suffers. The clinic caters to a wide demographic that focuses on Burmese refugees. Often during our elective period, a patient would arrive from a rural Burmese village speaking a local dialect. Consent obtained was often implied and language barriers meant that risks were not explained. The lack of traditional training of the majority of those practising dentistry in Mae Tao also prompts questions of the clinician’s full understanding of the associated risks and benefits of extractions. The WHO checklist was not explicitly used in the clinic; whilst certain aspects of the checklist did feature during the extraction process there was no sure way to encourage safe surgical practice. The most noticeable difference was the lack of routine radiographs, due to high cost.

Thanks to the Bristol Dental Alumni Association we were given the invaluable opportunity to observe dentistry in a foreign country. We were allowed a fascinating insight into the differences between extractions performed in a remote, under-developed area and those carried out at Bristol Dental Hospital. Whilst we had anticipated some of the differences, others amplified the simplicity of the service provided. Our experiences have made us ever grateful for the education we receive at Bristol University.

We had a wonderful trip and combined our elective with travelling throughout Thailand, Laos and Cambodia. Without the BDAA none of this would have been possible!