Blood money: quality of life and aesthetic dentistry

Having a blood transfusion is normally a simple, straightforward procedure that patients and healthcare professionals alike consider to be safe.

But those of us who are familiar with the 'tainted blood' scandal, which infected thousands of people with serious blood-borne diseases in the late 1970s and early 1980s, will know that it was not always so.

The scandal saw nearly 5,000 UK patients contract hepatitis C, and 1,200 UK patients contract HIV, after blood supplies and blood products were insufficiently screened.

The blood in question came from 'high-risk' donors – which included prisoners in the US who were paid for their blood – and as well as UK patients, has affected patients in the US, Canada, Japan, China and France (Starr, 1998).

The patients come from all walks of life, from those infected during surgery and childbirth, to thousands of haemophiliacs being treated with plasma products derived from the blood in question.

The legacy of contamination

Make no bones about it: these patients have suffered years of illness and distress. By 2007 approximately 1,600 people had died as a result of these infections.

At the time, Lord Robert Winston described the scandal as 'the worst treatment disaster in the history of the NHS'. A five-year enquiry into the scandal in Scotland, headed by the former judge Lord Penrose, described it as 'the stuff of nightmares'.

An independent inquiry headed by Lord Archer of Sandwell in 2009 said that the main responsibility for the tragedy rested with the US suppliers of the contaminated blood products, and that commercial interests appeared to have been given a higher priority than patient safety.

Government ministers in the UK have never admitted culpability, although during his final months at Downing Street, the outgoing Prime Minister, David Cameron, formally apologised for the 'pain and suffering' the tragedy caused, and announced a £125million package of changes to the compensation these patients have been receiving.

The amount of compensation continues to cause much debate, but regardless of that, money alone cannot solve the impact that these events have had on patients' lives.

Rebuilding smiles

The volume of patients affected by this scandal means that some of our colleagues will have treated them over the years. The incident has certainly affected some of my patients, and I am sure that I am not alone in that.

But there is no discussion in the profession about these events.

Of course, we have a strict duty of confidentiality to our patients, and we should be grateful if they trust us enough to open up to us. Nor should their conditions affect the special precautions we take in treating them – yet recent studies have shown that many health professionals treat hepatitis C patients differently (Richmond et al, 2007).

There are many issues related to quality of life for a patient suffering from a chronic disease. And although there is little information about their need for aesthetic dental treatment, I think it is nevertheless an important consideration for us all.

What impact can a smile improvement have on a patient already suffering from a chronic disease?

There are two aspects to consider here (MacAskill, 2016). Will aesthetic dentistry provide a health benefit to a patient? And will this intervention improve the quality of life for the patient while they are alive?

For example, on average, people with untreated AIDS typically rate their live as '50% as good as life at full health', while people rate life after a stroke as '75% of life at full health'. People with moderate depression, meanwhile, rate life at '30% as good as life with full health'.

All this should lead us to how we consider aesthetic treatment planning for patients suffering from a chronic illness.

These days, much of aesthetic dentistry involves a minimally invasive approach, which allows us to make simple smile improvements that can improve patients' self-esteem without much intervention – and this can be a tremendous bonus for a patient.

How many patients who have contracted chronic disease are also suffering from depression related to the illness?

That is for another discussion, but what we do know is that many patients suffering from hepatitis C require dental management for oral infections (Mahboobi et al, 2014; 2015), and their oral health needs to be stabilised prior to the patients commencing interferon treatment (Nagao et al, 2010).

What impact does improving the smile have on healthy patients? We know that it can be profound – so imagine how much more it can be for a patient living with chronic disease.

All these questions need to be considered. The story of tainted blood, its related blood money and the result of a global contamination of blood products have major ethical and moral implications for the health service, governments and for patients suffering from these diseases to consider (Xiaomei, 2014).

If aesthetic dentistry can improve the quality of life for our patients, then as a profession we owe it to them to offer it.

Linda Greenwall
BDS MSc MGDS RCS MRD RCS FFGDP(UK)
Editor-in-chief – Aesthetic Dentistry Today

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