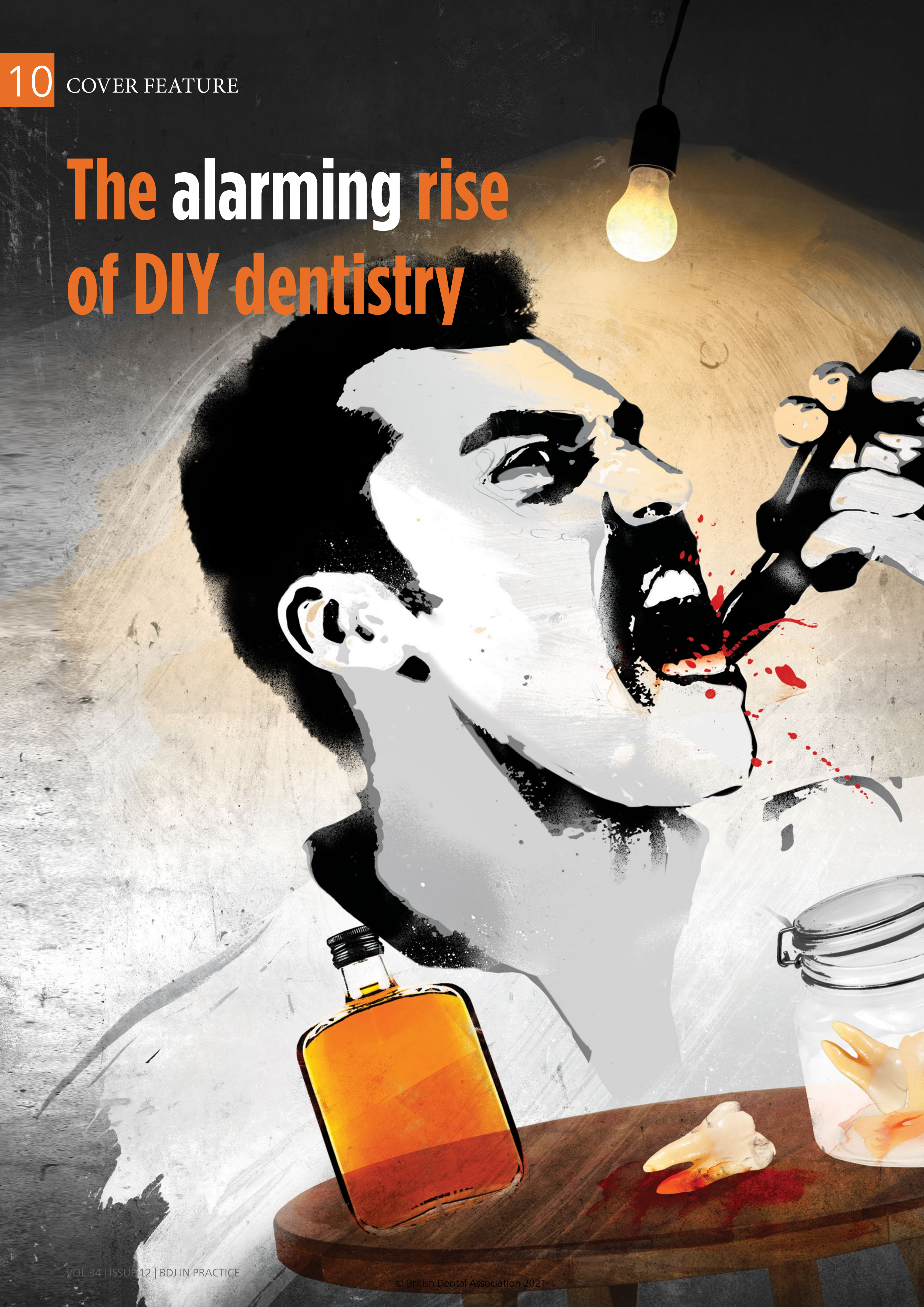
The alarming rise of DIY dentistry



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Key points

- Reports of patients pulling their own teeth out is nothing new, but are they on the rise?
- Identifying some of the root causes
- Can anything really be done?

Introduction

In December 2016, I wrote a long-read piece about how dentistry could – and was – helping those experiencing homelessness.[1] In that piece, the spokesperson for the charity Groundswell said: '*The fight for funding from Clinical Commissioning Groups is getting tougher and it leaves less room for innovation. This is a problem on its own, but drug and substance misuse interventions, alcohol misuse interventions and mental health services – to name but a few – are all having their funding cut. People who find themselves homeless are often at the extreme end of social exclusion. All safety nets in place to catch them – i.e. the services having their funding cut – have failed them. It leaves them with an air of distrust and a lack of understanding of how to navigate the system.*'[1]

It led to me being invited to a meeting in early 2017 with Pathway where I vividly remember hearing first-hand what it was like to experience homelessness and the lengths people go to when they cannot access the healthcare services they need.

Almost five years on from that article these problems persist, and are perhaps worse than ever. While Crisis say there is no national figure for how many people are homeless across the UK – homelessness is recorded differently in each nation, and because many homeless people do not show up in official statistics – they also suggest that for the last five years core homelessness has been rising year on year in England, reaching a peak just before the pandemic when the numbers of homeless households jumped from 207,600 in 2018 to over 219,000 at the end of 2019.[2]

As a result, it's little wonder reports of patients taking their own teeth out are also increasing.

A long-standing problem

When initially scoping out the scale of the issue and doing my research for this article, one of my sources said the issue of DIY dentistry was overblown, it was largely confined to those experiencing homelessness and largely borne out of the pandemic. Eye-opening, but from someone better placed than me to have such an opinion. So, what did the research say? In 2017, research revealed 15% of homeless people pulled out their own teeth.[3] In late 2020, 25% of households across the UK attempted at least one form of DIY dentistry.[4] Earlier on in the year, the British Dental Association (BDA) had urged government and the Commons Health Committee not to ignore the growing crisis in NHS dental services, as reports emerged from Plymouth of patients performing DIY tooth extractions at home in the face of 14,000 strong waiting lists.[5] Only last month did the BDA also report that several cases had emerged of patients embarking on DIY dentistry. One patient told the BBC she removed 11 of her own teeth, while others reported removing six teeth, waiting four years to secure an appointment, and one woman in North Norfolk facing seven-hour round trips to access care in Kent. And finally, as far back as 2006, the following is an excerpt from a letter published by the *BDJ*:

'It led to me being invited to a meeting in early 2017 with Pathway where I vividly remember hearing first-hand what it was like to experience homelessness and the lengths people go to when they cannot access the healthcare services they need.'

'Sir, we saw a 40-year-old male heavy goods vehicle driver of middle class background via an access centre in Airedale Primary Care Trust complaining of dental pain in his upper left quadrant. His medical history was clear, his periodontium healthy and he had last visited a dentist some four to five years previously, since when his general dental practitioner (GDP) had discontinued NHS dental services and the patient could not afford private dental care. Despite multiple attempts he could not re-register with another GDP.

The patient had suffered severe pain occurring randomly, lasting between 30-60

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minutes, which could not be localised, with associated sleeplessness for the previous two nights. However, he disclosed that he knew exactly the tooth which could be the culprit, since he had a history of a lost restoration in the upper left seven (27) three years previously with minimal discomfort. The tooth had been treated twice in the past three years, by the patient himself!

On questioning he revealed that to debride the cavity he used a holiday-dental-kit comprising of plastic mirror, forceps and probe combined with an electric toothbrush with a small round head. For convenience, the patient had trimmed the bristles to fit into the cavity. He had used tactile senses for plugging the filling material into the prepared cavity, using a material called Quick Steel bought from a DIY motorcar parts retailer.[6]

There have also been multiple reports in national tabloid newspapers and in local news about patients resorting to DIY dentistry, and all of those reports – be it the patient using a material from a motorcar parts retailer, those experiencing homelessness or those within the pandemic – boil down to the same, central issue: access.

Fundamental issues

It's been much publicised for many years now about the problems people in the UK face trying to access NHS dentistry – with dramatic headlines becoming all too common. A quick search suggests there have been access problems for decades, and yet there are still those who point to the pandemic as the problem, and its disappearance as the solution.

After the 2019 General Election, the BDA had urged the government to act on the mounting problems in NHS dental services, following the gains which saw the Conservatives take control of an overwhelming majority of England's worst access hotspots.

There followed an open letter to then Health Secretary Matt Hancock, in which the BDA urged the government to factor in dentistry as it presses ahead to put its NHS plan into law, recognising both mounting recruitment and retention problems, and the service's unique status as the only part of the NHS family operating on a lower budget than that received in 2010.

The breaching of the so-called 'Red Wall' in the Midlands and North of England has seen the Conservative Party make headway in areas with acute access problems. This includes towns like Dewsbury in West Yorkshire where residents routinely receive support from the charity Dentaid, a charity normally operating in the developing world.

In the 50 clinical commissioning groups (CCGs) reporting the highest number of patients who have tried and failed to secure an appointment, the Government gained 10 seats, leaving nearly two thirds (64.2%) of constituencies (149 constituencies in total) represented by Conservative MPs.

Analysis of the Government's GP Survey undertaken during the election revealed that across England over 1.4 million adults were estimated to have tried and failed to secure an appointment. Unmet need for services stood at over four million when factoring in those on waiting lists, those put off by treatment costs, and over two million who did not believe they would be able to secure an appointment.

'As the pandemic swept the country, things deteriorated. Access wasn't restricted, it was cut off. Hospitals had re-deployments of bed space and surgical staff, meaning GA waiting lists – which in some parts of the country were already terrible – were extended.'

Further back in time than this, the BDA also highlighted patients in Penzance, Bodmin, St Ives, Falmouth, and Newquay had a single practice in Redruth reporting they were able to take on new adult NHS patients, forcing families to undertake up to 65-mile round trips.

Commitments made since 2010 to make a decisive break from the discredited 2006 NHS contract which effectively sets a cap on patient numbers have yet to be honoured. Despite pledges to put prevention and primary care at heart of the NHS 10 Year Plan, no commitments were made to guarantee the future of high street dentistry. There is currently funding to provide care for little over half the population, with spend per head on high street services falling by £4.95, from £40.95 to £36, in the last five years.

As the pandemic swept the country, things deteriorated. Access wasn't restricted, it was cut off. Hospitals had re-deployments of bed space and surgical staff, meaning GA waiting lists – which in some parts of the country were already terrible – were extended. Community services – in this case domiciliary care – was massively impacted. After all, it was in-home care for a reason. NHS high-street dentistry felt the biggest impact.

The result? Survey data from the BDA point to an exodus from the service as the access crisis continues with nearly 30 million appointments lost since the first lockdown. The crucial issue for me was the nearly half (47%) of dentists indicating they are now likely to change career or seek early retirement in the next 12 months should current COVID-19 restrictions remain in place. The same proportion state they are likely to reduce their NHS commitment.

Doesn't sound like a problem caused by the pandemic to me.

It reminds me of something my mother used to have when I was younger. To non-Russians, the matryoshka, or nesting doll, is one of the most quintessential representations of traditional Russian peasant life. It is a small wooden doll, almost perfectly cylindrical, painted to resemble a peasant woman in a traditional Sarafian dress holding a rooster. She opens to reveal a smaller doll, which opens in turn to reveal yet another doll, and so on. In total, there are seven dolls in addition to the mother doll; they consist of five girls dressed in similar fashion, a boy doll, and a tiny baby at the centre.

Dentistry resembles the matryoshka. You could arrange dentistry, DIY dentistry, access, funding, the 2006 Dental Contract, recruitment and COVID-19 in any order and it'd still make sense.

A new DIY definition

Reports of patients unable to access a dentist and resorting to removing their own teeth is grim – I don't think there's any other word that really does it justice. Money has always been seen as a hurdle for those in the most deprived areas unable to afford a check-up, and so *of course* NHS dental charges have continued to increase.

Cost is a barrier for the most basic of need, but increasingly it's also a barrier for those wishing to improve on what they already have. The rise in 'cosmetic DIY dentistry' alongside what I'd loosely term 'pain-related DIY dentistry' centres not on any of the aforementioned matryoshka, but firmly on the patient's apparent desire to cut corners and save money.

A contentious statement? Maybe, but when broken down, maybe not. Tooth whitening

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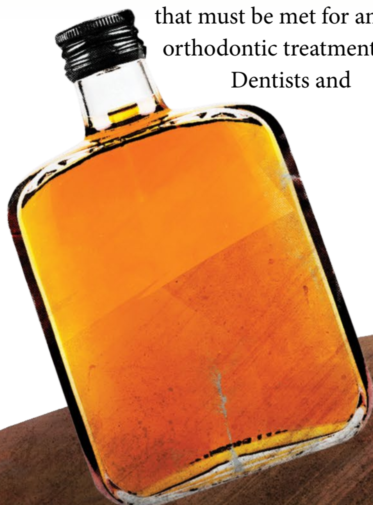
leads the way, with orthodontics catching up at a rate of knots. Why else would, in 2012, the EU Council Directive 2011/84/EU need to set out who can use what strength of product when carrying out tooth whitening? When it comes to dental tourism, Ashiti and Moshkun, writing in the *BDJ*, said it best:

'*Many UK patients in the search for their perfect smile have now decided to have their dental treatment abroad, the main reasons being that they believe they can have the same treatment but at a much lower price. With many overseas clinics offering treatment packages that also include a holiday, dental tourism seems an opportunity not to be missed. Although not always the case, some treatments unfortunately do not go to plan, often leaving distraught patients and their apprehensive dentists in a difficult situation.*'[7]

When discussing the reasons behind dental tourism, they went on to say:

'*If they cannot afford private treatment in the UK, they may therefore opt instead for treatment abroad, where one clinician in a limited number of appointments can offer everything at a low price, thus obtaining the final result more quickly.*'[7]

This new-found desire for obtaining results quicker and without having to visit a dentist in the UK has had wider repercussions than anticipated. A recent Europe-wide consensus saw 31 professional dental and orthodontic societies, associations, and institutions from 25 countries come together to endorse and fully support a Joint Declaration regarding the unacceptable and potentially unsafe remote treatment of malocclusions. This Declaration by the European Federation of Orthodontic Specialists Associations (EFOSA) stated the basic requirements that must be met for any orthodontic treatment. Dentists and orthodontists all over Europe are witnessing the increasing activities of start-up companies promoting and selling orthodontic treatment using aligners by post with great concern. This type of remote treatment is provided without either proper initial diagnosis or any form of regular clinical monitoring. These companies often present their services as affordable, fast, and safe, although they clearly do not meet required professional dental standards. Orthodontic treatment without proper initial diagnosis and regular clinical monitoring can cause severe risks to patients' health.



> 'This comes hot on the heels of a new campaign asking all patients considering treatments to visit dental practices in the UK and have treatment conducted by clinicians registered with the GDC.'

In announcing the Declaration, Professor Christian Scherer, who coordinated the project for EFOSA, said: 'The unanimity shown by European orthodontists on this subject makes it clear that orthodontics is more than just aligning the front teeth. It is about a holistic approach to care where the patient's best interests are at the heart of our treatments.' Every patient should make sure that the basic requirements formulated in the Joint Declaration are also observed in his or her treatment so that their treatment is practised safely.

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Safe Smiles is a professional response to concerns about the growth of direct-to-consumer alternatives, with the campaign's two organisers – the Oral Health Foundation and the British Orthodontic Society – worried about patients performing treatments at home potentially putting themselves in danger. Commenting on the Declaration, Anjli Patel, Director of External Relations for the British Orthodontic Society said: 'Orthodontic treatment without thorough clinical face-to-face examination of the patient, x-ray imaging and regular clinical monitoring, is potentially hazardous to the patient's health. Any self-administered and remote treatment cannot be justified from a professional medical perspective and thus represents a serious violation of ethical, medical and dental standards.'

For once, I'm not sure this particular problem has its roots in politics or decision-making in the upper echelons of dentistry. *The Guardian* reported British households built up their savings to the second highest level on record at the start of the year as the COVID-19 lockdown limited opportunities to spend, according to official figures.

In a development economists said could pave the way for a boom in spending as pandemic restrictions are relaxed, the Office for National Statistics said household savings rose sharply in the three months to the end of March 2021 as the third national lockdown constrained spending.

The saving ratio – which estimates the amount of money households have available to save as a percentage of their total disposable income – rose to 19.9% from 16.1% in the three months to the end of December, reaching the second highest level since records began in 1963.

The previous record of 25.9% was set in the second quarter of 2020 during the first lockdown as the British economy plunged into recession.

This has led to various reports of a 'Zoom boom' and rise in cosmetic procedures, as patients have more dispensable income to invest in whatever they want. Only time

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will tell whether this has set a permanent course of reversal from DIY dentistry,

Can anything really be done?

While DIY dentistry is a patient issue, it really has NHS dentistry at the heart of it. Private practitioners may find themselves being asked to fix dental tourism gone wrong, and hospitals may need to deal with infections caused by botched at-home extractions, but if access was better, rising patient charges were addressed, adequate funding was provided and contract reform actually progressed, would this article even exist? Would this conversation be consigned to history?

> 'These problems are nothing new. Quite the opposite – they appear to be long-standing and deep routed within the profession. And it is clear it is patients who are losing out.'

Sometimes I wonder if I pick on the NHS too much. Sometimes I wonder whether there's a bulletin board in the office of the Chief Dental Officer England with a dart board and my face on it. The reality is delivering on a reformed and better resourced NHS primary care dental contract that is based on a preventive care pathway should have been a top priority for transforming NHS dental care and putting prevention front and centre since the current one was introduced 15 years ago (and counting). In my opinion, successive CDOs in England have not progressed the conversation sufficiently. Yes, no-one could have foreseen the damage the pandemic would do, nor how long it would last, which has seismically changed dentistry (and its cloud still looms), but where was the conversation in 2019? Was it tangibly any different to where it was in 2015? If NHS dentistry is going to be able to attract the workforce needed to meet the oral health needs of the population and reduce health inequalities, the contract is at the heart of that.

Another of these issues is recruitment. Again, the pandemic has had its impact, but is that covering for the impact – widely reported across the NHS – Brexit has had? One of these issues on their own is difficult enough to deal with, but together they're proving to be exceptionally challenging. A better contract means more of the profession happy with their NHS commitments, which means fewer access problems, which means fewer reports of DIY dentistry.

For those experiencing homelessness, by and large they're having to rely on charity to have their needs met. Is this a sustainable model? Probably not. Given the backlog of patients, financial pressures and for those still in post-pandemic recovery, even if they wanted to offer their time, can they? At the time of writing the same SOP required at the height of the pandemic appears to be changing to include two pathways, a welcome relief but one which makes it challenging to treat this – and other – cohorts of vulnerable patients. In Wales, for example, Minister for Health and Social Services Eluned Morgan MS has pledged additional funding for access to NHS dental services in Wales, allocating up to £3m to Health Boards in 2021-2022 to expedite the recovery of services and bolster urgent and emergency care and an additional £2m in recurrent funding from 2022-23 to allow Health Boards to increase access and capacity needs over the medium term. A very welcome pledge, but there are no indications additional funds will be made available to community dental services.

In Scotland, the situation appears – from the outside looking in – confused. Dental charges for those age 1-25 have been removed as part of the SNP's commitment to scrapping NHS dental charges for everyone in Scotland. In addition, £7.5m was pledged to help practices buy new equipment to aid in their post-pandemic recovery, but then in October, Cabinet Secretary Humza Yousaf wrote to all NHS dental teams stating that all emergency support will be withdrawn by 1 April 2022. Since the first lockdown, NHS practices have operated under a COVID-19 support package, reflecting pandemic pressures and tight infection control restrictions that continue to limit capacity across the service.

In Northern Ireland, 500 high street dentists have written to Health Minister Robin Swann to call time on the dire situation facing Health Service dentistry, urging the Department of Health to set out tangible solutions to overhaul the decades-old General Dental Services (GDS) contract. The BDA reported that latest published figures show dental earnings in Northern Ireland have fallen once again, by an average of 4.2% compared with the previous year, or 36% in real terms for associates and 43% for practice owners since 2008/09. Those with the highest commitment to Health Service dentistry (75% or more) have recorded the lowest earnings of all, averaging taxable income of £49,700 in 2019/20.

These problems are nothing new. Quite the opposite – they appear to be long-standing and deep rooted within the profession. And it is clear it is patients who are losing out. The story I was told at Pathway all those years ago simply should not have happened, let alone be something on the increase. Doesn't the thought of someone drinking so much alcohol, taking so many pain killers, grabbing a pair of pilers and pulling their own tooth out send shivers through the spine? Does it not shame those at the very top of policy-makers that these incidences are happening on their watch and being facilitated by their inaction? It should, because these are some of the most vulnerable individuals in society, and the current dental landscape is failing them.

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