surrounding career opportunities like funding and hiring decisions. The recommendations given are for funding agencies, institutions, publishers, organisations that supply metrics, and researchers globally. Interested parties can add their names to this Declaration.[2]

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Teledentistry

Forestalling collateral damage

Sir, I read with interest the recent publication entitled 'Head and neck cancer presentations in the emergency department during the COVID-19 pandemic'.[1] The collateral damage due to the COVID-19 pandemic due to neglect and delayed diagnosis of concurrent oral and other systemic diseases is now well known. This article clearly illustrates the case in point, and highlights a mere sliver of the UK population where such neglect led to increased severity of their disease, occasionally with deadly outcomes. The profession should now learn from this experience and appraise how such pandemic-induced collateral damage could be forestalled in the future.

One approach that could lead to significant remediation of this situation is the wider use and popularisation of teledentistry, defined as 'the remote facilitating of dental treatment, guidance, and education via the use of information technology instead of direct face-to-face contact with patients'.[2] This is particularly true when viral diseases such as monkeypox are re-surfacing,[3] and COVID-19 is declared an endemic infection with its variant viral subpopulations.[4]

Currently, there appear to be several challenges in adopting teledentistry as a care management tool, such as its novelty and the resulting reluctance among both dentists and patients to accept it. These concerns need to be allayed to popularise its utility, which will undoubtedly come of age as a robust diagnostic and patient care management tool owing to the increasing use of cloud-based data services, artificial intelligence (AI), and big data resolution through bioinformatics.[5]

It is time that authoritative professional bodies promulgate guidelines on the use and utility of teledentistry, and universities include it in their curricula as an integral health management tool. Further, teledentistry can also complement the current compromised dental health management systems in the UK.

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NHS dentistry

Post-Brexit NHS money?

Sir, the recent BBC reports on 'dental deserts', where NHS dental practices are unable to accept new patients, have opened a fresh, public debate on our profession's heroic efforts to provide a viable service to our patients.

The Brexit campaigners promised the electorate that leaving the EU would repatriate £350 million per week for spending on the NHS, making £18.2 billion per year. There would have been many demands on that money although even a portion of that would have covered the costs of many courses of dental work, but where has that money gone? Was the electorate sold a lie?

There is a catastrophic lack of staff across the NHS, including dental practices, and we certainly know where many of the NHS staff have gone: post-Brexit working conditions made them so unwelcome here that they have gone home to their EU countries. I have always been impressed by how my NHS colleagues have worked ridiculously hard in order to balance the conflicting demands of providing a professional level of dental care, within the draconian constraints of the 2006 contract, and keeping their practices financially viable. My respect for my NHS colleagues is huge.

An alarmingly dystopian vision has recently been added to the mix by the recent *BDJ* articles which encourage dentists to question the 'strategic importance' of a tooth before deciding which treatment to provide, on account of the restricted NHS funding. I am sure that we all can think of other aspects of NHS work which are of less strategic importance than enabling people to have a healthy, functioning mouth, but the money can be found for those services. Again, where is the promised Brexit money for funding the NHS?

Not only is the whole of the NHS falling apart, due to its lack of funds and staff, but my work as a magistrate has shown that the same is happening within the judicial system. Southampton's court house, where I sit, has six available courts but we regularly have only one of those courts in action, leading to a vast backlog of cases and a lack of justice for the victims of crime. Our probation colleagues have ridiculously high targets to meet, without being given the funding and resources to make those targets remotely achievable. Does that problem sound familiar? In the meantime, work has been proceeding on enabling people to travel between Birmingham and London in 20 fewer minutes, at a cost of at least £110 billion. Who really wants to be able to do that, at a cost of £5.5 billion per minute, especially now that so many meetings can be equally effective when conducted remotely? Who can doubt that the obscene amount of money needed for this vanity project would have brought so many benefits to the NHS? Where is our promised, post-Brexit NHS money?

C. Marks, Southampton, UK

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Dental care professionals

A forgotten workforce?

Sir, the UK has invested heavily in the education and training of dental hygienists and dental therapists but has never established appropriate conditions to allow them to exercise their skills fully.

Oral healthcare professionals with qualifications in both dental hygiene and dental therapy are able to undertake approximately 70% of primary care dentistry. In the UK, almost all education in this field is offered as a three- or four-year Bachelor of Science (BSc) programme in Oral Health Sciences. The standard of education is robust,

comprehensive and quality-assured by the General Dental Council (GDC). The learning outcomes contained within the GDC document *Preparing for practice* are almost identical for undergraduate dentists and dental hygienists and therapists, other than those skills which are outwith the scope of practice of the latter group. Much education in dental schools is shared between BDS and BSc undergraduates, and the expectation is that levels of knowledge will be largely the same in the common subject areas. It could be argued that given the narrower curriculum for BSc undergraduates, they may have a greater experience of primary care dentistry by the end of their training.

Direct access for patients to these professionals was granted by the GDC in 2013, meaning that a prescription from a dentist was no longer required to allow them to undertake the clinical treatment for which they had been trained. However, the full potential of these individuals has been shackled by regulations and indeed by some in the dental profession itself. One wonders why this group of highly skilled individuals has been forgotten or overlooked? Is it intentional, an oversight or perhaps driven by those who consider that they may endanger the monopoly of dentists in the provision of routine dental care?

The lack of recognition of the skills of dually qualified dental hygienists and therapists has led to their de-skilling and demoralisation. It is a waste of a workforce which could make a substantial contribution to addressing the unacceptable levels of disease in the population. If permitted NHS List (Provider) numbers and prescribing rights for simple procedures such as the administration of local analgesia and the application of fluoride therapies, they could work in partnership with GDPs and others to reduce these constantly escalating problems.

Whilst these observations may not solve the lack of dental care in the UK, they may serve as a reminder of the contribution that an extended, willing and able workforce is able to make. The question remains: are these professionals forgotten, ignored or a threat to those who do not wish to recognise teamworking, and the skills of non-dentists in the health and wellbeing of our population? The silence of governing bodies and governments is deafening.

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DIY dentistry

Vodka-assisted extraction

Sir, in view of the reported rise in DIY dentistry, we thought it would be useful to apply some quantum to this and provide a snapshot analysis of patient presentations at a new patient clinic over a two-day period at Peninsula Dental School.

We recorded whether patients had carried out self-administered dentistry, and of the 38 patients attending over two days, 13 reported doing so. This figure of 34% of patients (with its limitations) is an increase on the reported 25% of households across the UK attempting at least one form of DIY dentistry in late 2020.[1]

There was a wide range of treatment modalities attempted with five patients carrying out temporary restorations, using materials and instruments purchased from a pharmacy. Two patients had adjusted their dentures, one with a nail file and one with some sandpaper.

A patient who presented with necrotising periodontal disease had brought a scaler online and tried to manage the condition (unsuccessfully). Another patient, rather than purchasing a scaler, had used a dart to remove gross deposits of calculus.

There was a range of oral surgery procedures evidenced. One was a failed extraction with pliers of an upper right first molar, with the patient applying the pliers but finding it too painful when the procedure commenced. One patient reported that they had treated a friend by trying to extract the affected tooth by tying string around the tooth, attaching it to a door and slamming it shut akin to a cartoon – and again unsuccessfully.

The patient in Figure 1 had attempted to extract 13, drinking enough vodka to dull the senses, then quickly using standard pliers to extract the tooth, with further vodka to relieve the post-operative pain. The patient was aware the root was left *in situ* but found this had relieved pain sufficiently to warrant repeating the procedure three further times, over an approximate two-year period.

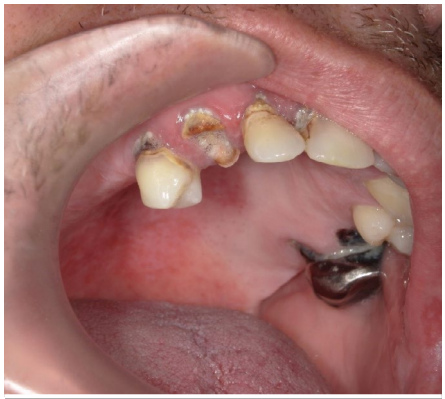

Fig. 1 Failed vodka-assisted extraction of 13

While this is just a snapshot analysis, we are increasingly finding that patients accessing our services have attempted to access dental care elsewhere unsuccessfully and we are observing a worrying rise in DIY dentistry. The risks to patient safety from these attempts are not insignificant, and while dental access problems persist, more public information is required on the risks of DIY dentistry.

E. McColl, R. Witton, A. Mathews, Plymouth, UK

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https://doi.org/10.1038/s41415-022-5045-5

Digital dentistry

Manchester is Epic too

Sir, we were pleased to see the recent paper 'Going electronic, an Epic move', by Virdee *et al.*,[1] on the move towards using Epic as a fully integrated electronic paper records system in a specialist dental teaching hospital within UCLH.

Over recent years, the Manchester University NHS Foundation Trust has formed from previous NHS Trusts, District General Hospitals and Community Services, to now be the largest NHS Trust, with around 38,000 NHS and academic employees and students working in ten hospitals and community Local Care Organisations. There are over 1,000 individual IT systems and several million patient records (either paper, digital or hybrid) within the Trust. This arrangement presents considerable logistical and efficiency challenges and contributes to patient safety risks. Therefore, with an ambition of being a single, digitally enabled hospital, MFT NHS Trust embarked on a process of transformation towards a fully integrated, digital healthcare system. We have called this process 'Hive', to reflect both Manchester's long adoption of the worker bee symbol and the unity created by integrating our systems and processes.