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.

M. K. Ross OBE, Edinburgh, UK

https://doi.org/10.1038/s41415-022-5041-9

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.

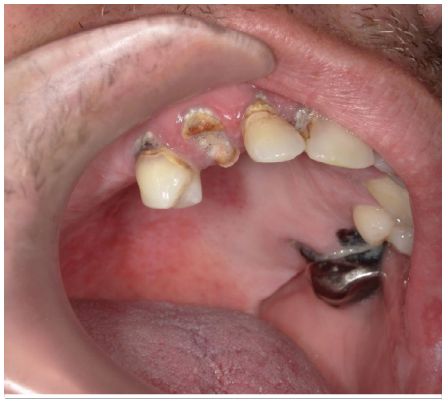

Fig. 1 Failed vodka-assisted extraction of 13

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.

MFT NHS Trust chose Epic to power our Hive transformation, as it offers a proven record of delivering the level of integration and transformation required. In addition, as Epic is already relied upon in a number of NHS Trusts and working towards implementation in several others, there are clear opportunities to benefit from collaboration with an increasing group of large NHS organisations.

MFT NHS Trust chose from the outset to include Wisdom within our Epic implementation and have supported development of this module to be entirely suitable for use within an NHS specialist dental hospital environment. Indeed, UCLH have also recently added Wisdom to its own Epic installation as have Guy's and St Thomas's Trust and Health and Social Care Northern Ireland, who are both currently working towards their own go-live date, anticipated in 2023.

Our University Dental Hospital of Manchester, within MFT NHS Trust, is at an advantage as several years ago, we transitioned almost all our clinical records into the SALUD Dental Hospital EPR system, so our staff and students are familiar with the concept of working in a digital system. However, we are now aware of the considerable benefits offered by Epic as a true fully integrated electronic health record. Hive will deliver the service efficiency and patient safety improvements that we require, but also remove so many of the inefficiencies and personal frustrations that exist when trying to work within a much larger healthcare organisation. In addition, Hive has ensured dental services at MFT NHS Trust are fully integrated within all its other healthcare services.

M. Ashley, R. Needham, Manchester, UK

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https://doi.org/10.1038/s41415-022-5044-6

Patient communication

Interpretation is key

Sir, we read with interest the letter by P. Watson[1] regarding the challenges with interpretation services when organising and providing dental care to people who have fled persecution and found sanctuary in the UK. We fully agree that more needs to be done by the system to support these people and the dental teams who want to provide care.[2,3]

In our experience, communication difficulties and translation have been identified as fundamental barriers to accessing care.[4] These can range from patients being unable to make an appointment due to the lack of interpretation services, to difficulties in obtaining consent and appropriately explaining a treatment plan to a patient in the available appointment time.

For example, not all interpreters are fully aware of dental terminology and few receive specific training in dentistry; it can therefore take a long time for dentists to explain, in lay terms, the proposed treatment to patients. Where written translation is required for a treatment plan, this can be problematic when a translator cannot write as effectively as they can verbally translate. Using a telephone interpreter, rather than an in-person interpreter, can also increase appointment times. For NHS dentists in particular, spending time using an interpreter may drive up the costs of providing treatment to unaffordable levels. The cost of written translation is currently not provided by NHSE which acts as a further barrier to care.

Unclear lines of communication can cause frustration for both the patient and the dental team and particularly in our experience, when there are differences in dental cultural norms. Miscommunication can also act as a deterrent for patients with high needs to seeking further dental care. Although having a dentist who speaks the same language providing care is preferred by some patients, current NHS guidance requires professionals to undergo a 12-week training course before they can treat in a language other than English, which is unrealistic for most dentists.[4]

Revision of existing NHS interpretation protocols but also investigation on how language support can be provided in a culturally appropriate manner would undoubtedly be important in improving patient experience for this patient group.[4] In addition, flexible models of care are required to meet the needs of patients with additional language needs.

M. Paisi, H. Wheat, J. Horrell, A. Jebur, R. Witton, Plymouth; P. Radford, Barnsley, UK

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