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Case Study

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QUACKERY A QUANDARY- FATE OF DENTISTRY EVEN IN 21ST CENTURY- CASE SERIES

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ABSTRACT

Since the services of qualified practitioners are not easily accessible to colossal majority of the population, the gap is bridged by the ubiquitous unqualified practitioner. In many developing countries of the world where dental health-care facilities are limited, the underprivileged of the society go to unqualified persons (known as quacks) to get dental treatment. This mockery of dental practice imparts unethical dental care to people and results in complications. It is thus a challenge to the dental practitioners to not only fight against this fraudulent of dental quackery but also to educate and convince the patients to distinguish between the quacks and dentists, so that they get guided to take the right treatment. It is incumbent upon dentists everywhere to protect this hard-earned reputation by weeding out quacks from among them. The present article emphasizes on the deleterious practice which the quacks exercise for the replacement of natural teeth.

KEYWORDS: Quackery, Dental Quacks, Street Dentistry, Oral Health.

INTRODUCTION

Dental diseases are inarguably one of the most prevalent diseases in our community, yet have been neglected for long by the general population. However, since the past two to three decades the increased awareness, literacy, emphasis on esthetics, advanced and sophisticated dental treatment equipments, and economic development have led to complete turnaround in the field of dentistry in India.[1] The ultimate goal of any profession is to provide quality and standard service to people; which are governed by a set of rules and ethical principles. Ethical practice determines people's behaviour and resides in the realm of human values, morals, individual's culture, interpersonal beliefs, and faith.[2]

Quackery has been defined as, "the fraudulent misrepresentation of one's ability and experience in the diagnosis and treatment of disease or of the effects to be achieved by the treatment offered."[3]

Street dentistry, a form of quackery, is still in practice in rural and remote places. These street dentists often visit villages on their bicycle with a bag consisting of some pliers, screwdrivers, dividers, self-cure acrylic materials. Quackery is a derogatory term used to describe the fraudulent misrepresentation of the diagnosis and treatment of diseases. It is the practice of ineffective medicine which is unproven and is usually preferred in order to make money or to maintain a position of power. Random House Dictionary describes a Quack as a fraudulent or ignorant pretender of medical skill or a person who pretends, professionally or publicly, to have the skill, knowledge and/or qualifications which he or she does not possess; a charlatan.[4]

When dental professionals are disproportionately allocated to the private sector relative to the public sector that provides subsidized services, financial affordability becomes a barrier in the care of the people belonging to lower economic strata. People who cannot afford specialty treatment prefer to go to cheap unregistered dental practitioners. The high cost of dental treatment, illiteracy, lack of awareness, poor accessibility to dental clinics, and repeated dental appointments are the reasons for which most patients are drawn towards quacks. Since, quacks guarantee their patients painless and immediate treatment, rural people opt to go for such treatments with immense faith in unqualified medical quacks.[3,4]

The history of dental quackery runs parallel to that of quackery in the field of medicine. It is said that the 17th-

century French physician Pierre Fauchard started the art and science of dentistry as known today. In the 19th century, dental quackery was plentiful in Colonial America and the British colonies such as Italy.[5]

This practice has been the preferred treatment modality among the lower socio-economic group even in today's contemporary and scientific world. India has been witnessing a sharp escalation in the number of quacks who have been creating a menace by the means of their illegitimate practice, especially in rural areas. Parts of Uttar Pradesh, Bihar, Haryana, Karnataka and Tamil Nadu are effected by the presence of street dentistry. These itinerants open roadside clinics and perform procedures on pavements amidst a highly pathogenic environment. Practicing under such septic conditions leads to various complications, which we have tried to cover here under our case presentation. This review article presents two case reports about the illegitimate practice of quacks and discusses the notorious effects it has on the dental health.

CASE REPORT 1

A 48-year-old male patient presented to the Department of Prosthodontics complaining of mobile fixed partial denture in upper front teeth region along with halitosis for the past one month. The patient had no history of any major medical illness. The previous dental history of the patient was he having visited a roadside person practising dentistry in a major metro city of India where he was provided with the fixed denture prosthesis for both upper and lower anterior teeth. The patient's upper fixed denture prosthesis when removed was found to be suspended with the help of stainless-steel wire to the maxillary canine teeth on both the sides **(Fig 1)**. After removing the so-called fixed denture, we noted severe tissue damage along with erosion of the gingiva in the anterior region and severe recession and mobility of all remaining natural teeth.

The patient also had severe halitosis along with inflammatory changes on the gingiva in the anterior region. The natural teeth around which the stainless-steel orthodontic wire was placed were completely holding the fixed prosthesis and the existing natural teeth showed severe bone loss with generalized periodontitis.

The patient also showed us the visiting card of the quack which gave us an indication that it was a case of classical quackery. The patient was informed that his comprehensive treatment plan would include extraction of this fixed prosthesis along with the other mobile and hopeless natural teeth, followed by a complete or removable denture placement.

Fig 1: Patient with prosthesis tied to adjacent teeth using stainless-steel wires.

CASE REPORT 2

A 53-year-old male patient reported to a dental check-up camp organized by the Department of Prosthodontics and Public Health Dentistry at Sri Hasanamba dental college and hospital, Hassan, Karnataka. On examination, an acrylic partial denture was found replacing 11. The partial denture was tied to the adjacent natural teeth (21, 22, and 23) by using a cotton thread **(Fig 2).** The teeth were apically fractured. Dental history revealed that 5 months back, the patient had got his tooth extracted from a road side dentist and got his teeth fixed 2 months prior to coming to the dental camp. On further questioning, the patient revealed that he got his missing teeth replaced by a road side dentist at a minimal cost without harming the adjacent teeth and tissues, while the dentist in the city told him that all the natural teeth with poor prognosis needs to be extracted and the prosthesis would be fabricated for all his missing teeth and it could not be done immediately. Patient decided to get his treatment done from the quack and was satisfied with the treatment provided by the quack.

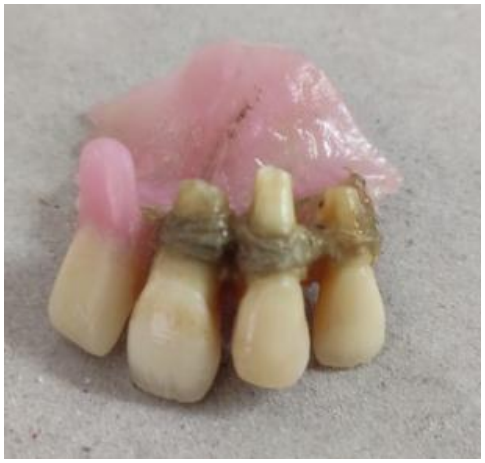

Fig 2: Patient with prosthesis tied to adjacent teeth using cotton thread.

CASE REPORT 3

A 47-year-old female patient reported to the Department of Prosthodontics at Sri Hasanamba Dental College and Hospital complaining of pain in the upper front teeth and lower left back teeth region for the past 2 weeks. The

patient had no history of any major medical illness or any recent hospitalisation. On examination, the patient had a prosthesis in the 11, 24, 25, 31, 33, 34, 35, 36, 37 and 41 regions. The so-called prosthesis was firmly attached to the adjacent teeth using self-cure acrylic **(Fig 3)**. The patient had a unilateral open bite on her left posterior region. The so-called prosthesis was ill fitting and was removed using a bur by cutting it. The gingiva presented with severe inflammation and was enlarged in the posterior region. The patient also had grade II mobility of 21 and 32 which were wrapped around using self-cure acrylic. The other findings included severe generalised periodontitis and generalised cervical abrasion. The dental history of the patient revealed that the patient had visited a person on roadside who had offered her some dental solution 2 years back and decided to get the treatment roadside as it was an immediate and ephemeral process unlike going to a dentist. This indicates that the patient was treated by a quack and the treatment was done without abiding by the norms and guidelines established for rehabilitation using a prosthesis.

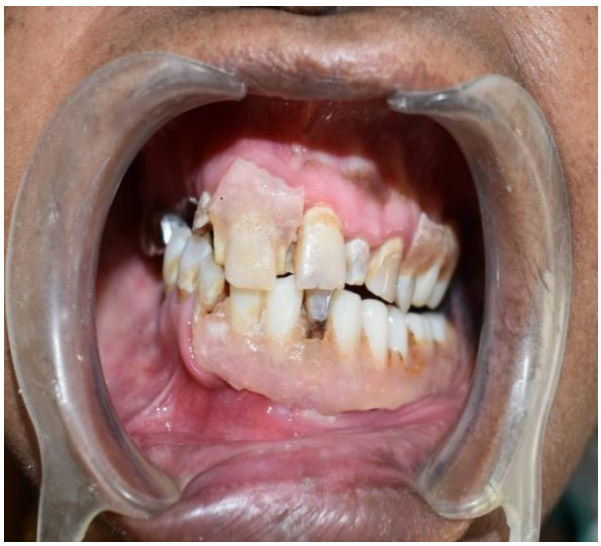

Fig 3: Partial Denture prosthesis fabricated using self cure acrylic.

DISCUSSION

The cases presented above are just a few among the many which are taking place all over the world. Hence, it calls for pertinent measures to be taken to tackle the same. But in order to address the problem, we first need to identify the reasons which are causing it.

Most of the quacks learn some dental work while working as an assistant in dental clinics. They acquire some knowledge by simple observation of the dental operating procedures with no scientific knowledge and then start off their own practice in rural areas at a lower cost, without using any technology and modern modalities. They are least concerned about the sterilization of their instruments and device their own instruments according to their convenience which has no scientific basis.

Anti-Quackery Laws should be implemented and effectively executed. In India, under Chapter V, Section 49 of the Dentist Act of 1948 require dentists, dental mechanics, and dental hygienists to be licensed. These quacks can be penalized under The Dentist Act leading to imprisonment and penalty, but stricter laws need to be enforced and implemented.[6,7] Quacks guarantee their patients a painless and immediate treatment. Dental quacks cater to the lower socioeconomic classes that cannot afford qualified dental practitioners. The rural people blindly go for such treatments with immense faith in these unqualified medical healers. The problem also arises because these quacks otherwise also known as street dentists display on their boards “RIMP”, which stands for “Registered Indian Medical Practitioner” when in reality there is no such degree. This makes them appear real to the common man.

The World Health Organization suggests having New Dental Auxiliaries like dental aid, dental licentiate, and frontier auxiliaries with little training to work in rural remote areas. Until the government intervenes, in doctrines the health system, and provides a stable means of income, there are more chances that the quacks may thrive and earn money by practicing quackery.[3,14] The best defense against quackery is an understanding of how scientific knowledge is developed and verified. Dental education should include instruction on the scientific method and the detection of quackery.[3,8]

In the end, the future of quackery depends on how deep and strong is the symbiosis of quacks and qualified practitioners. The earlier that symbiosis is broken and the rational care is made universally available, the earlier will quackery recede. The government and dental council should put forward a strong policy to culminate these unethical practices harming the population.

CONCLUSION

The rising demand towards dental health care services and the crisp shortage of qualified practitioners to meet this demand is the predominant cause for existence of quackery. Though the overall dentist population ratio in India is 1:10,000, at present in rural India, one dentist is serving 2.5 lakhs of people. Only 15-20% of people in India are able to get dental services through national schemes, and 80-85% are spending money from their pockets, providing an ideal breeding ground for quackery into dental practice in India. This hiatus between demand and supply needs to be addressed to culminate this unethical practice. Apart from dental check-up camps, dental treatment camps should also be conducted to provide treatment in rural health care settings. Awareness regarding oral health should also be increased by imparting health education to the population, especially in the rural areas. With effective implementation of policies and laws, this immoral practice can be completely uprooted from existence.

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