The Good, the Bad and Regulation
Neel Kothari discusses the thorny issue of regulation in dentistry

As we slowly move out of the naughties and into the teens our expectations of change within the world of NHS dentistry is marred by the troubled early years of the 2006 dental contract. Since its dawn, much of the discussion regarding the system has focused on one thing: what will be replacing it? The economic crash has meant that finances to fund this change have been restricted and that any change is most likely to be in the second half of the teens, as political will is diverted towards fixing broken Britain, both economically and socially.

The teens may end up being a rebellious period for dentistry and we may have to wait until the twenties before we can trust the architects of the new-new dental contract to make sensible decisions.

So why the title The Good, the Bad and Regulation? Well, as a profession that is constantly changing and required to meet the highest of standards, in my opinion the decision making over what regulations are needed should also meet the highest of standards.

Good regulation does more than set a benchmark; it drives the profession in a positive direction. It is without doubt in everyone’s interest and historically has been embraced well by dental professionals. Ever since Joseph Lister introduced carbolic acid (phenol) to sterilise instruments and clean wounds, medicine has always looked for evidence that can help save patients’ lives. So when the Scottish government announced that primary care dentists in Scotland will not be required to use vacuum sterilisers because there is a lack of evidence that they would increase patient safety, the question that naturally arises is: where was the evidence that they were better in the first place?

Bad regulation ends up costing more than just money – it instils a great deal of future mistrust between the government, dentists and patients. We all recognise that the cost of complying with regulations is increasing and as such it is only natural to question their necessity and efficacy. For example, if we look at the regulations which state our need for Legionella testing, to what extent is this actually good for patients? Could the financial and time burden involved in carrying this out be better spent? At what point do we say we shouldn’t do this because the risk of this is so small that we probably expose ourselves to a greater risk by getting up and going to work?

Perhaps the question we need to ask is: what level of risk are we prepared to accept?

Apart from lining the pockets of those with vested interests, with many of the so called ‘best practice’ regulations it is hard to see a decent cost/benefit to patients. But bad regulation doesn’t just stop with cross infection; within the last couple of months Health Service Ombudsman Ann Abraham publicly named and shamed a dentist for failing to apologise to a patient who claimed that he had been rough and had hurt her
while trying to take X-rays, and also that he had been rude to her when she had objected. She described leaving the appointment feeling ‘battered emotionally and in more pain’. Despite a response from the dentist, the patient was dissatisfied with this and took the matter further to the healthcare commission who amongst many things recommended that the dentist pay her £500 compensation for the feelings of shock and offence she had suffered.

Now I’m not suggesting that all the facts of this case are known, but what sort of world are we living in when a dentist can have his reputation denigrated in the court of public opinion, an intentional attempt to damage his livelihood and be labelled by the media as ‘Britain’s rudest dentist’ all for attempting to check his patient for dental disease? At what point does someone need to step in and suggest to the patient that they may be overreacting?

In actual fact it is more than likely that the dentist didn’t actually force her into enduring what the patient had coined ‘emotional battering’ and that clinically his actions were not negligent, so why do the regulators feel that monetary compensation of £500 is needed? I’m not saying that the patient’s grief is irrelevant, but does the punishment really match the crime?

In my opinion there certainly is a need for regulation here, but not in favour of the ever increasing presumption that patients are always right and dentists are always wrong. In the aforementioned case the regulators really need to consider his other patients who may be very happy with his manner and are now subject to unnecessary doubt regarding his professionalism. I have no doubt that the patient felt upset at the end of her treatment, but unless we apply the standard of common sense (which I accept is relatively uncommon), it is the government and dentists that end up worse off.

I’m not sure how much this whole fiasco has actually cost the taxpayer, but if it that money was put towards dental treatment costs, just think of how many patients would be better off! Implementing any regulation without justifying its cost and benefit to patients not only runs the risk of being bad regulation, but is simply no longer sustainable. Many trades support the business of dentistry and whilst dentists in good faith have purchased equipment such as vacuum sterilisers, if it is proved that many of the items purchased are actually not needed, the next wonder product that comes out may lead to a situation similar to that of the boy who cried wolf.

I commend the Scottish government for their application of common sense. Of course good regulation should help to protect patient’s interests: this is a given principle. But this principle should also be applied fairly across the board; for those dentists who are found in breach of any regulation, surely the punishment should match the crime.

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