Regulations and relative risks

The only thing worse than over regulation is bad regulation, says Neel Kothari

My biggest pet hate at the moment is the sheer number of unenforceable policies designed to induce a culture of fear and promote the practice of defensive dentistry. In my opinion the only thing worse than overregulation is bad regulation and by keeping the profession at a safe distance from the construction of such regulations, this not only renders the policies as ‘short term’, it severely erodes the profession and its ability to self-regulate.

The promise of a cut in bureaucracy by the incumbent government has quickly evaporated, leaving dental practice managers trying to understand complex protocols and policies designed for small hospitals and clinics rather than a general dental practice.

For instance, let’s look at the costs and the risks associated with Legionnaires disease and the need for a risk assessment and regular water testing. If you get a ‘professional company’ (apologise for the inappropriate use of the word professional) to carry out a full risk assessment and test the water sources you could easily pay more than £300 for the privilege. Money well spent or a complete waste of time? I guess that’s a matter of opinion.

Low risk

A risk assessment of dental unit waterline contamination carried out by Caroline Pankhurst in 2005 concluded that ‘the risk to respiratory health from bacterial contaminants in dental unit waterlines is very low’ and at the Second Annual All Island Symposium on the Public Dental Services the reports state that one in three homes contain Legionella, but there is a very low attack rate in an outbreak, just 2-5 per cent. Legionella flourishes in all water types in temperatures of 20-45 degrees Celsius, and likes stagnation, sediment and scale. It goes on to further state that ‘There are no proven cases of Legionnaire’s disease linked to dental treatment’. The question then becomes, is forcing dental practices to adhere to Legionella testing a cost effective way to promote public policy? And should practices really divert time and money away from front line services?

Relative risk is something that seems to be completely absent from the architects of HTM01-05, which may go some way to explain why the DH review of HTM 01-05 has been further pushed back to 2013-14 and why the BDA as our trade union has pressed for the immediate removal of the unnecessary and burdensome restriction on instrument storage times, which the DH has conceded is not evi-
dence based on a number of occasions.

On my recent CQC practice inspection I was visited by my local CQC inspector that I should have a sign saying ‘dirty’ to indicate which side of the clearly marked dividing tape that dirty instruments are to be placed. My immediate response was no. Even though this is probably a show of personal defiance, I really do not want a sign saying ‘dirty’ anywhere in my room. Now some of you may think stop being silly and just play the game, whilst others may agree with my position, but either way, what a complete waste of time and money to make dentists mark the areas of their surgery ‘clean’ and ‘dirty’ and then pay someone else to enforce this.

The reality of modern day dentistry is that central government is far more concerned with the perception of how clean our instruments look and feel rather than the skill with which we use them. The move towards getting our instruments to be ‘sterile’ rather than ‘clean’ is not only expensive and time consuming to achieve, but does not address the fact that the relative risks of using ‘clean’ instruments is very low. After all restaurants don’t steam sterilise their knives and forks, yet we are all happy to put them in our mouths. Now I am not trying to compare a night out with dental treatments, but the relative risks to people still the same?

Outcomes
My understanding is that the CQC is monitoring things on an ‘outcomes’ basis. So let’s look at things on an outcomes basis. Since the introduction of the nGDS, CQC and IHTM01-05, dental practices have seen a massive reduction in morale, a hike in practice expenses, a reduction in profits and a ridiculous amount of time wasted formulating policies and protocols that neither stand little chance of actually being enforced nor have any solid evidence that they actually improve outcomes. When will central government realise that you simply cannot legislate dentists to do the right thing when it is debatable whether there is anything wrong with what we are currently doing.

As I have already mentioned, in my opinion the ever increasing burden of legislation being forced onto general dental practices is really designed for small hospitals and not for family practices. Whether or not they are actually enforceable is debatable.

if you go into any busy A&E on a Saturday night I bet you will see a number of ‘breaches of cross infection compliance’ ranging from nurses taking bloods without gloves and smoking outside whilst wearing hospital tunics. Let’s not forget that they are treating people who are seriously sick and not simply carrying out dentistry in relatively healthy patients.

The relative risks to patients are clearly much higher compared to a general dental practice, yet nevertheless I have to spend my lunch breaks debating whether I should have a sign saying ‘dirty’ in my surgery, which until I absolutely have to I will not be doing. Furthermore, why am I told that I need a sign showing me how to wash my hands every time above my sink? This is one of the first things that we learnt at dental school and simply just adds to the clutter of useless posters that do little to improve standards for patient care. Why not get dental nurses to hold open a textbook every time we prepare a cavity or a crown for a tooth?

Apologies for the rant. I will try to cheer up in time for my next article.

**About the author**

Neel Kothari qualified as a dentist from Barts and the London School of Medicine and Dentistry, qualified as a dental surgeon at the Eastman Dental Institute and is currently undertaking the postgraduate diploma in implantology and is currently undertaking the Diploma in Implantology at UCL’s Eastman Dental Institute.