# The artful science of politics

Stephen Hancocks OBE
Editor-in-Chief

Send your comments to the
Editor-in-Chief,
British Dental Journal,
64 Wimpole Street,
London
W1G 8YS
Email bdj@bda.org



The current controversy over the sacking by Home Secretary, Alan Johnson of the chairman of the Advisory Council on the Misuse of Drugs, Professor David Nutt will doubtless pass fairly quickly into the history book of minor public skirmishes. Apart from the significance of the Professor's view of the classification of drugs the other notable aspect was the vehemence with which the decision was defended. It serves to highlight the serious disconnections that exist between scientific fact (evidence base) and political dogma, the assessment of risk and the application of policy, and the practice of defensive public strategy. Such inconsistencies are well known to us in dentistry.

It was Professor Nutt who caused earlier controversy by suggesting in a comparison of relative risks that drug harm can be equalled by other aspects of life that involve risk-taking behaviour; likening the dangers of taking ecstasy to those of horse-riding. Howls of indignation went up at that time from the then Home Secretary Jacqui Smith (perhaps statistically, losing a job as Home Secretary is a greater risk still) declaring that the claim trivialised the dangers of the drug. Yet I suspect it was the social gradient of the comparison that caused political correctness to come into play. The sordid drama of collapse through ecstasy, tinged with crime, in a sweaty inner city night club probably seemed more immediately socially relevant than the trauma from a riding accident in a leafy country setting, despite both being tragic in their own terms.

## EVIDENCE EXISTS – IF REQUIRED!

It does leave one wondering about the government's attitude to decontamination. We have had the imposition of single-use endodontic files because of a 'theoretical' risk of cross infection control by prion proteins, yet no scale of evidence has been forthcoming to allow a judgement on how theoretical or otherwise the risk may be. We now also have the edicts of HTM 01-05 which require the use of, amongst other things, washer-disinfectors in primary dental care and an assurance in a letter to this journal by the Chief Dental Officer of England that it is evidence based.[1] Somewhat disingenuously one feels, the letter also states that 'over 60 references to the published scientific and clinical literature were used in its compilation. A list of these references is currently being compiled for publication if required.' If required? Surely this is in jest? If they are already published how long does it take to compile a list? No research paper submitted to this or any other reputable journal would be considered if it arrived with a statement that the references would follow in due course 'if required', let alone one which had such far reaching practical and economic consequences as HTM 01-05. Despite a promise to the BDA, at the time of writing the elusive list has still not been received.

We therefore have to take someone's word for it. It might, of course, be sensible guidance but how are we able to judge? Without our knowing it might also be politically expedient guidance based perhaps on the defensive premise that if it isn't enforced and a patient contracted an infection as a result of dental treatment the government might be culpable. Yet how many cases of MRSA, for example, are traceable to dental practice as compared with hospitals? We are not told but the belief is none. In contrast, the recently published report from the National Creutzfeldt-Jakob Disease Surveillance Unit[2] makes interesting reading. It details that between 1995 and 31 December 2008, a total of 167 cases of definite or probable vCJD had been identified in the UK. Devastating for those individuals and families involved but hardly what one could term a public health crisis. Comparisons might be odious and possibly inappropriate, but by the time you read the next issue of the *BDJ* two weeks hence, about the same number of people will have been killed on our roads in a fortnight as contracted CJD in 13 years.

So what am I trying to say? In the first instance I am asking for some honesty about whether an evidence base exists or not, and if it does some further educated discussion about the seriousness of the risks. But I believe that we also need some clarity in thinking between the application of science, the estimation of risk and the formulation of public policy. Cost benefit is always a harsh term to introduce when health is concerned but to put the argument back into a road safety context, the likelihood of eliminating fatal accidents at railway level crossings could be achieved by building a bridge over each and every one in the country; but at what price?

No one would ethically suggest that we abandon cross-infection control, or indeed expose our patients, our teams or ourselves to unnecessary risk of microbiological contamination. However, equally, no one in practice for the public good should be compelled to implement guidelines, the evidence for which has not been published in the accepted way, that have not been openly risk assessed and that smack of a political expediency removed from the reality of that which other evidence suggests is prudent. It takes at least two parties to cross-infect, the same number as it does to establish trust.

1. Cockcroft B. A legislative requirement. Letter. *Br Dent J* 2009; **207:** 303.
2. The National CJD Surveillance Unit. *Seventeenth Annual Report 2008: Creutzfeldt-Jakob disease surveillance in the UK*. Edinburgh: NCJDSU, 2009. www.cjd.ed.ac.uk

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