Letters to the Editor

Send your letters to the Editor,
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Priority will be given to letters less than 500 words long.
Authors must sign the letter, which may be edited for reasons of space.

LETTERS

CRASS ADVICE

Sir, we write as concerned dental patients but particularly as microbiologists. We consider that as educated patients, we have a right to venture an opinion about measures to prevent cross infection in dentistry (cleaning, decontamination, disinfection and sterilisation).

We are aware that the Department of Health has issued a new guidance document coded HTM 01-05 and have read this with a degree of astonishment. We are convinced that infection will mainly occur in the surgery, and between people. Consequently we consider that surgery practice methods, design and techniques should be the first priority. The literature and our own observations would confirm that current dental practice is far from robust regarding prevention of spread of micro-organisms. We have noted over the years some apparently ill-organised and random alterations to dental practice that would appear to offer little or no worthwhile preventative benefits to staff and patients, eg changing autoclaves from recycling water to once only use, which in today's climate of reducing power consumption and conserving water, seems outrageous. To then require that these same autoclaves are now replaced with yet more that do nothing more than produce a record of validation is crass, bordering on incompetent advice. However, this in itself must be the subject of another letter and time.

In the meantime, HTM 01-05 appears to focus on 1) process validation and 2) removal of prions. Perhaps laudable, but, to what purpose? Any workable system designed to validate a process can be defeated. Can we be assured that, for instance, an instrument dropped on the floor and possibly re-used will fail vali-

dation? In such a case it would have come out of a bag correctly sealed and identified with date of processing recorded. This is but one example of how validation could be rendered meaningless.

In the past, we have used the expression that the procedures for decontamination, disinfection, cleaning, and sterilisation represent the 'hardware' requirements for minimising cross infection. Surgery practice, on the other hand, represents what might be termed the 'software'. If ineffective control of this 'software' aspect is not in place, then no amount of sophisticated hardware can compensate.

Removal of prions is also an issue, so it is again with surprise that we note the recommendation for use of washer disinfectors which will heat instruments to 90°C. We suspect that a basic knowledge of biochemistry and a search through the literature will confirm that this could, far from removing/destroying prions, 'fix' them (cause them to adhere more securely to instruments). We are not in any case aware that cross infection with prions in the dental surgery has ever been an issue.

Can it be that death from vCJD is a problem in dentistry and we hadn't noticed? Thus we have to ask why surgeries are being forced to adopt a hospital type of process that will render equipment sterile as if for use in operating theatres in a sterile environment, when there is no requirement for dentistry to be conducted under sterile conditions.

As patients we can see only the increased environmental load and cost to patients as a result of advice which seems well meaning but inappropriately onerous. We suggest that practice in the dental surgery may be lax and that steps should be taken to improve this before exercising concerns over the largely the-

oretical risk from prions. By all means autoclave instruments and, in the case of a large practice, a washer disinfectant may be a useful device (albeit run at lower temperatures as autoclaving will follow washing in any case).

We have heard of dentists being told on continuing professional development (CPD) courses as a GDC requirement that 'instruments must be sterilised but these don't need to be sterile for use in the mouth'. Since dentistry doesn't happen in a sterile environment many health care professionals think and say there is no need for dentistry to be done with sterile instruments. We consider this is an unhelpful notion but understand the logic. Since the dental care professional doesn't work in a sterile operatory environment then there is little purpose in sterility, it would seem. It is odd therefore that having gone to the extremes of HTM 01-05, a dental professional can then easily contaminate those instruments before the instrument goes to the next patient's mouth, safe in the knowledge that those instruments have been subject to a validated process, packed then stored for no more than 60 days! Now where did 60 days come from? Most hospitals adopt 365 day shelf life post-sterilisation.

HTM 01-05 needs to be discarded and rewritten focussing on the software first! Our advice to dental surgeries is look carefully at your surgery methods and refuse to accept the DoH *apparent* 'Legislative Requirement' until it has been scrutinised by a qualified body of people (acceptable to us as patients) who can debate the issues and reassure us that it will provide health precautions that are necessary and affordable, and that dental surgeries are not being coerced to procure equipment with dubious economic

and scientific benefits and, for that matter, who benefits? Dentistry is already a costly branch of health care to the end user and in the public perception.

As patients we are expected to accept evidence-based treatments. In this event, we cannot accept that dental professionals can advance the patient's interests by conforming to requirements that have a weak evidence base. Please be assured that we are attempting to be constructive in offering these comments.

J. M. Ewart

A. A. Jack

Codsall

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EASTMAN CONCEPTION

Sir, I recently attended the Eastman Dental Institute with my granddaughter who is receiving excellency in dental treatment there. We were fascinated to see on the directions board in the entrance hall that apart from the Paedodontic Department where we were heading there was also listed the Assisted Conception clinic. As a retired dental practitioner have I missed something?

G. H. Allen

Gerrards Cross

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OFFICIAL FAILURE

Sir, I was asked by a patient to provide him with a letter in relation to his application for a passport. He had to confirm his right to hold a British passport by verifying the information he had given on his application form by obtaining a letter that showed where he lived in the past three years. This could be provided by a number of individuals or organisations and were listed on the covering letter from the Identity and Passport Service of the Home Office as follows:

- Your bank or building society
- Your employer
- Your landlord or mortgage company
- Your school or university
- Your local authority
- The Department of Work and Pensions
- Your dentist, or only if absolutely necessary, your GP (We ask that you do not trouble your doctor for non-medical reasons if it can be avoided)
- A Commanding Officer.

It would seem from the above that we,

as a profession, have failed to establish with officialdom that our time is anything like as valuable as our medical colleagues!

S. I. Morganstein

London

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EVALUATING TECHNIQUES

Sir, 'ADAPT' (Aesthetic Dentistry and Professional Testing) invites registered dentists to apply for vacancies as ADAPT evaluators.

ADAPT was formed in 1993 and is accredited as a Specialist Society. The work of the society involves regular meetings where new and improved techniques for the provision of quality aesthetic dentistry are discussed and evaluated. Additionally materials are provided by the dental industry for clinical use and reporting.

Membership entails regular attendance at the monthly evening meetings at a London venue.

Dentists who are interested in taking part are invited to supply a short CV to 'The Chairman ADAPT', email howard-stean@ukteeth.com.

Additional background information is available on www.adaptuk.org.

H. Stean

By email

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MEMBERSHIP TARDINESS

Sir, I write as a follow-up to your editorial *Dental or dentist* (BDJ 2009; 207: 656). I recently attended a highly successful BDA section meeting which qualified for verifiable CPD in a core subject. I was asked by some of the invited DCPs why BDA membership is not yet open to them.

DCPs have to be registered with the GDC, they need to have professional indemnity and they need to have CPD. Finally DCPs can and do run dental practices. Why is it then that the BDA is being so tardy in expanding its membership to these essential team members? Does the BDA wish to lose these potentially valuable members to other disparate organisations?

M. Austin

Hove

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