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Does the Dental Regulator know the meaning of quality care? [1]

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My dental surgery presented me with a two page medical history questionnaire to complete before being allowed to see the dentist. You know the form. As nothing had changed since the last one, I offered to sign and date a copy. That was not an option because (a) their technology didn?t not permit extracts or copies (a likely tale) and (b) completing a new form was a legal requirement. They meant it was a Care Quality Commission (CQC) requirement. ?May I see at least last year?s as a prompt? At my age, memory is imperfect: I cannot remember my medications when the tablets are at home.? ?No. You have to complete the form unaided.?

The Adam Smith Institute has long drawn attention to regulators failing because they descend into box-ticking. The financial crash of 2008 was one example. [3] The CQC is a new regulator but this descent is already apparent. Ensuring primary care achieves and maintains high standards is clearly important and was given impetus by the Harold Shipman tragedy. But that is my point: whilst Shipman was good at the paperwork and complying with regulations, he was also killing his patients. The Mid Staffs Hospital is not a primary care unit but the issue is the same: they could have been ticking all the boxes and still killing their patients.

The CQC?s 2nd Annual Report sets out five criteria for establishing dental care quality:
(a) Do the dentists treat their patients with respect and discuss their proposed treatments?
(b) Do they fully assess patients? needs and deliver the care and treatment they need?
(c) Do they protect patients from the risk of abuse and treat them in a clean surgery without risk of infection?
(d) Do they recruit staff effectively and conduct thorough checks on them?
(e) Are patients? records up to date and kept safe and confidential?

Incidentally, there is nothing here banning the use of copies of prior records. Item (c), however, is responsible for the new ban on coffee in dental surgeries. According to my dentist, the CQC claims that this could give rise to cross contamination with medications even though there is no evidence that such a thing has ever happened. Harold Shipman would have passed these five criteria with flying colours.

Patients visit dentists to retain their teeth as long as possible and, when that fails, have false teeth fitted, all in as agreeable and painless a manner as possible. We want our teeth to look good too. The word ?teeth? does not even appear in the CQC criteria and nor does the patient experience. ?Quality?, in this context, means that we have teeth that work, avoid pain and look good. It would not be difficult to develop scales for these quality indicators. Adjusted tooth loss rates could be measured in a similar fashion to Professor Sir Brian Jarman?s adjusted mortality rates for hospitals. The CQC does interrogate some patients but their conclusions rely mostly on what they glean from dental surgeries. This is the wrong balance: patient experience, and especially the pain endured, is only known by the patients themselves. When the care quality of each surgery, relative to equivalent surgeries, is established, its patients should be informed. The aggregate scores in the CQC annual reports, all around 90%, tell us nothing.

Links:
[1] http://www.adamsmith.org/blog/healthcare/does-the-dental-regulator-know-the-meaning-of-quality-care
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