LETTERS TO THE EDITOR

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ORTHODONTICS

Why 50?

Sir, your informative and thought-provoking orthodontic themed issue (*BDJ* 2015; **218:** issue 3) provided a timely insight into orthodontic treatment in the same month that NHS England produced the final draft of its '*Guide for commissioning dental specialities – orthodontics*', which has some sensible guidance for commissioning, supported by the evidence and literature.

However, there is a requirement that anyone providing orthodontic treatment must conduct at least 50 case starts per year, which I understand from members of the working group is in the 'interests of patient safety'. What is the evidence base for this requirement? An electronic search of the literature produces none. A survey of the orthodontic workforce[1] considered an orthodontic provider to be a specialist or a non-specialist who treated more than 30 cases per year. Why does NHS England now consider 50 to be the 'magic number'?

Two audit papers[2,3] show that clinical assistant (CA) training produced good quality outcomes very similar to consultants and specialists in both hospital and general practice. The volume of cases treated was not found to be an indicator of the quality of outcome.

I underwent CA training 20 years ago with our local consultant and have worked part time in the department ever since. As a GDP I carry out 40 case starts per year in the general dental service. 'PAR' scores of my completed cases show 70+% are improved or greatly improved and I am sure that there are many other GDPs who are in a similar position. I have no objection to my work being judged on its merits using a recognised indicator but am now at risk of losing the orthodontic part of my contract based on an arbitrary number.

Since CA training was the only realistic way forwards for most of us it seems discriminatory that my generation now runs the risk of losing part of our livelihoods, and the NHS of losing our experience, based on a whim that will also variously disadvantage our patients. I would be very grateful if someone at NHS England would point me towards the evidence on which this requirement is based.

P. Thornley,
by email

1. Robinson P G, Willmot D R, Parkin N A, Hall A C. *Report of the orthodontic workforce survey of the UK*. Sheffield: University of Sheffield, 2005.
2. Purkiss C. Collaborative clinical audit. Outcome of orthodontic treatment. Practitioners accepting referred orthodontic patients in Shropshire. *BOS Clinical Effectiveness Bulletin* 2004; **17:** 5–6.
3. Hand D P, Khalaf K, Mattick C R. Assessment of orthodontic treatment outcome using PAR score for patients treated at the orthodontic department of a teaching hospital. *BOS Clinical Effectiveness Bulletin* 2010; **24:** 12–14.

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DENTO-LEGAL

A modern-day *Wolf Hall*?

Sir, having acted as an expert witness in general dentistry on behalf of the defence team for several registrants in hearings at the General Dental Council in the last few years, I feel moved to comment on how distressing this situation is, obviously particularly for the registrant, but also for those of us involved with him/her at the hearing. Those registrants with whom I have been associated have been living with the threat of losing their livelihood, sometimes for two or three years. The stress, depression and personal problems that this causes are truly awful. Many seem to feel very isolated because of the humiliation they feel. It is difficult for them to see that and realistically their situation seems to me to be one in which any dentist might find themselves.

The standards by which we, as reasonable and competent dentists, are judged are those of absolute perfection and I would defy any general practice dentist to say that he or she could always meet these, especially retrospectively. I also believe that the vast majority try hard to do so in a challenging environment in which the goalposts are constantly moving.

Having come away feeling as though I was involved in a modern-day version

IMPACT ON THE AIRWAY

Sir, the article on dento-legal issues and risks in orthodontics by Ireland *et al.*[1] was most informative, but I would like to add a further consideration. There is some concern that traditional orthodontic protocols may negatively impact the upper airway. For example, Chen *et al.*[2] found decreases in the cross-sectional area of the upper airway following orthodontic treatment. Sharma *et al.*[3] also found a direct correlation between tongue position in the oro- and hypopharynx following orthodontic extractions, while Wang *et al.*[4] reported a correlation between lower incisor retraction and decreased retropalatal/retroglossal airway distances in adult patients. Bearing in mind these types of findings, some patient advocate groups believe that obstructive sleep apnoea (OSA) is caused by retractive orthodontic procedures. While patients should be informed of these potential risks, there are orthodontic/orthopaedic/pneumopedic procedures that dentists and orthodontists can provide to enhance the upper airway and reduce the possible risk of OSA.

D. Singh,
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1. Ireland I J, Willmot D, Hunt N P. An introduction to dento-legal issues and risks in orthodontics. *Br Dent J* 2015; **218:** 197–201.
2. Chen Y, Hong L, Wang C L *et al.* Effect of large incisor retraction on upper airway morphology in adult bimaxillary protrusion patients. *Angle Orthod* 2012; **82:** 964–970.
3. Sharma K, Shrivastav S, Sharma N, Hotwani K, Murrell M D. Effects of first premolar extraction on airway dimensions in young adolescents: A retrospective cephalometric appraisal. *Contemp Clin Dent* 2014; **5:** 190–194.
4. Wang Q, Jia P, Anderson N K, Wang L, Lin J. Changes of pharyngeal airway size and hyoid bone position following orthodontic treatment of Class I bimaxillary protrusion. *Angle Orthod* 2012; **82:** 115–121.

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