LETTERS TO THE EDITOR

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Email bdj@bda.org. Priority will be given to letters less than 500 words long. Authors must sign the letter, which may be edited for reasons of space. Readers may now comment on letters via the *BDJ* website (www.bdj.co.uk). A 'Readers' Comments' section appears at the end of the full text of each letter online.

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,
Beaverton, OR, USA

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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of '*Wolf Hall*', I cannot but think that there must be many occasions when dentists should not need to go through such rigorous investigation so that, as so frequently happens, s/he is found to have learnt from their mistakes and be free to go back to work without sanctions.

K. Winstone,
Longfield, Kent
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Fighting the stupidity

Sir, I think we need some clarification regarding the exact implication of standard 1.7.2: '...If you work in a practice that provides both NHS (or equivalent health service) and private treatment (a mixed practice), you MUST make clear to your patients which treatments can be provided under the NHS (or equivalent health service) and which can only be provided on a private basis.'

As far as I am aware there is no set list of treatments that can be provided under NHS arrangements and it is down to an individual's interpretation of 'clinically necessary and clinically cost effective' to quote the departing Chief Dental Officer for England. Before the 2006 fiasco (contract), we all knew the limitations of the NHS provisions and if we wanted to step outside these we asked for approval from the DRO service. Since the abolition of this body the system has been woolly at best. This leads to confusion in both patients and practitioners, in fact the whole *Which?* campaign of late could have been headed off by getting this ludicrous situation remedied.

I humbly suggest that every single NHS practitioner could potentially be found guilty of violating this standard completely innocently if, at an FTP hearing, the 'expert' witness decrees his opinion to differ from your own. This is a ridiculous situation for us, as professionals, to be in. I implore the BDA who represent us as a trade union to remedy this and publically call on the Department of Health to clarify their expectations. We risk our livelihoods at the whim of someone whose opinion may differ from our own. If I am mistaken then I would be grateful to see a copy of the full list of NHS approved treatments, as even the GDC could not provide me with one. If anyone out there can help please contact me, my address is on the GDC website (surprisingly!).

This is one battle the BDA should fight. They should partner with the GDC and *Which?* to produce clarity, as it is good for both patients and practitioners and would massively reduce the amount of stress within the profession, and confusion for patients. It would be a real win/win. We cannot hit an undefined standard, it's an impossibility! The BDA has recently shown its teeth and if we want dentistry to be taken seriously we need to keep fighting the stupidity that currently surrounds the NHS situation.

P. Woodhouse,
by email
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DENTAL EDUCATION

Galactic microscopes

Sir, I am continually surprised and disappointed regarding the number of recent graduates who seem not to use magnification as a matter of course for operative dentistry procedures.

Recently, whilst delivering various topics in the postgraduate arena to cohorts of dentists less than two years out of dental school, a show of hands in a group of around 12 (from a hybrid mix of training hospitals nationally) to the question as to '*who uses magnification (loupes or microscope) routinely as a part of delivering procedures to patients*?' produces a dismal three or four positives at most. Loupes are alien and microscopes are outer galaxy! Dreadful!

A similar result is forthcoming in that no one has ever shown them how to appropriately use a close support dental nurse to effectively help to deliver what are operator-demanding procedures less haphazardly. The parameters of the 1950s and even earlier hold sway.

Both of these areas are examples of where the long overdue use of even simple innovation will transform the way in which the microsurgical procedures of operative dentistry are delivered for patients and team. Can someone currently involved in teaching undergraduates operative techniques explain to me why this has gone unchanged for 40 or 50 years or more? Is there any surgical speciality that does not now use magnification routinely (let alone one that is 90% or more microsurgery – ie dentistry!)?

Nothing perhaps will evolve in any effective way unless the undergraduate schools address this. Maybe they do and graduates are not convinced? It also begs the question – do their teachers use magnification? Please enlighten me. Are these simple conclusions and my concerns totally wrong?

K. F. Marshall,
by email
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