COMMENT

Letters to the editor

Send your letters to the Editor, *British Dental Journal,* 64 Wimpole Street, London, W1G 8YS. 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.

The following four letters are in response to an Opinion article 'Cause for concern: BDA v GDC' published in the BDJ on 25 May 2018 (https://www.nature.com/articles/sj.bdj.2018.358).

Regulation

Treating colleagues with respect

Sir, I write having read the interesting and thought-provoking opinion piece of our retiring colleague R. A. Baker.[1]

It is always interesting to see what conclusions are made from an outside perspective rather than from being involved and having perhaps more detailed information. When he said 'treating colleagues with so little respect' I needed to re-read to check to whom he was referring, and was surprised that he referred to those at the BDA.

He refers to those at the CQC [Care Quality Commission] and GDC [General Dental Council] doing a 'thankless job' and hopes the regulators would be 'understanding and forgiving'. Whilst the CQC has changed dramatically with a change of leadership and a much better relationship with the profession, with the GDC to date, there has been no change of leadership.

He states that the BDA has had little impact in changing GDC policy, but I dispute that. Via a judicial review where the GDC was shown to have acted illegally, and by pressure on politicians, the Chair and Chief Executive of the GDC were summoned to a Health Select Committee in March 2015 to respond to the criticism laid. By the autumn, the Chief Executive had left.

He quotes a mantra to never litigate, I am afraid if I had taken his advice, from 2006 I would have a contract that allowed NHS England (previously the PCT) to terminate my contract for no reason and cause. Sometimes when things are so wrong and dialogue has reached an impasse, it is only the power of the law that rectifies the injustice. Being 'unfailingly polite' is never the same as being willing to listen.

He states we should 'accept regulation willingly'. The profession accepts regulation, but is a desire for a fair regulator an unreasonable ask? Should we willingly accept an unfair one? Ignorance I am afraid is never 'bliss' in the long term.

He states he was 'forced to go private' in the 1990s and that the regulator should not deal with 'the pricing vagaries of the NHS'. Many of our colleagues have not been able to follow his path but instead are working in a system that was castigated by the Health Select Committee a decade ago, and it is my assertion that the GDC should have been concerned with a contract not fit for purpose.

Indeed his many proposals for better practice have been incredibly difficult for practitioners seeing a 20-30% drop in income since austerity and yet still managing to provide excellent care for patients. I agree with him that 'we cannot hope for speed and thorough examination of a case at low cost. These are mutually incompatible', but it is the very system many colleagues find themselves in.

It is fanciful to suggest the raising of the ARF 'as necessary to ensure justice' is compatible in any form, as costs do not equal justice. Only a fair and proportionate regulator does that. Even the GDC accepts the placement of an advert for the Dental Complaints Service was a mistake. Sadly, Dr Baker thinks otherwise.

I hope I have been kinder than Dr Baker's consultant who he quoted and would like to wish him an enjoyable retirement in Portugal.

E. Crouch, by email

1. Baker R A. Cause for concern: BDA v GDC. *Br Dent J* 2018; **224:** 769–776.

DOI: 10.1038/sj.bdj.2018.652

Standards of conduct

Sir, most dentists would support Dr Baker's appeal[1] for mutual respect between representative bodies and the need for standards of conduct, especially for medical and dental practitioners. He concludes: 'In my lifetime regulation has changed from lose minimalism to rigid direction'.

However, I hope he accepts that standards need to be agreed and the more restrictive they are, the greater the risk for scientific progress.

J. Mew, Broad Oak, East Sussex

1. Baker R A. Cause for concern: BDA v GDC. *Br Dent J* 2018; **224:** 769–776.

DOI: 10.1038/sj.bdj.2018.653

GDC v the dental profession

Sir, Dr R. A. Baker[1] presents an impressive submission in the case of BDA v GDC. However it is somewhat incomplete.

Having retired some 28 years ago, I was a student at the birth of the 'free of cost NHS' in 1948 and can well remember the extent of the demand for treatment and the amount of untreated dental disease that presented. In part this was due to the shortage of available dental manpower during the war and the difficulty that some patients had in affording necessary treatment. It would be a pity if over regulation turned the clock back.

We live in a risk averse society in which it is necessary to determine blame and achieve compensation. Unfortunately, risk and activity travel together and the law of unintended consequences applies.

The cost of regulation has to be passed on and appears in the cost of treatment and should be proportionate. Whilst any misadventure needs to be avoided, cost/benefit analysis should be applied. It is not in the public interest that the effect of regulation should be such that practitioners

Official journal of the British Dental Association.

are unwilling to tackle risky but necessary procedures or prefer early retirement to the stress of practice and patients or the NHS are unable to afford the cost of treatment.

Dr Baker's paper states that there were 510 charges in a five-year period [an average of 102 per annum]. I understand that the GDC had paid for advertisements seeking complaints. This must surely be a misuse of registrants' fees as it encourages rogue lawyers to pursue fictitious claims.

According to statistics, in the five-year period 2013-17 there was an average of over 45,000 registered dentists. My geriatric maths makes the charges around 0.011% or one registrant for every 900 over five years. This is remarkably low compared to the performance of the Crown Prosecution Service or the record of MPs. The paper itself puts credit card fraud at 8.3%.

NHS Dental Statistics for England 2016-17 state that there were 39.9 million courses of treatment provided by 24,007 dentists who had performed NHS activity. Assuming that none of the average 102 charges applied to non-NHS practice [ignoring the many registrants in hospital, community service and private practice] this suggests that the incidence of charges is around 1:40,000 courses of treatment [ignoring the number of privately provided courses]. Whilst I do not condone malpractice in any form, I believe that these figures will stand comparison with any group including ministers of religion.

Accepting that human frailty makes zero risk unattainable, Dr Baker's paper fails to address the level at which over regulation becomes counter-productive.

There is another aspect of the GDC's activity that is not addressed in this paper. During my professional life, I have encountered many excellent dentists who, for valid reasons, have needed to practice on a part-time basis. They have made a valuable contribution to their communities. However, when the cost of registration, insurance and continuing professional development becomes excessive, part-time work is no longer viable and their skills and service are lost. This is not in the public interest.

Whilst Dr Baker concentrates his defence on the GDC and Dr Moyes, the BDA has to take account of the totality of regulation which continually grows. The latest concerns data protection. The burden of regulation appears to be becoming unmanageable in small practices. The future may belong to big corporates who can afford the fees of legally trained personnel to manage their compliance obligations. But would the closure of small practices be in the public interest? Perhaps in reappointing Dr Moyes, the Government has signalled that this is their objective? It may seem perverse but in condoning the excessive expenditure of the GDC, the Department of Health and Social Care allows more of the NHS budget to be diverted to non-clinical expenditure.

Dr Baker disparages the 'good old days'. My first six months in 'cons' was with a foot engine. Post-war scarcity ensured that there was much 'make do and mend'. There was no alternative to the hot water steriliser and I was amongst the first to use zylocaine. We treated AUG with chromic acid and hydrogen peroxide because today's medication was not available.

Not all new techniques have been successful. Inevitably there will be a period in which the new replaces the old. Perhaps we should remember that it is not the equipment which we use that matters but the manner in which we use it. In the 'good old days' we provided an essential service with equipment and materials that were the best available at the time. Today we would be 'struck off'.

I agree that all practices should update their equipment when necessary but to do so they need to be adequately funded. Money spent on registration and compliance with regulations cannot be used to upgrade equipment.

I must disagree with Dr Baker's criticism of you, sir! He suggests that you should 'moderate' controversy. Is this not an attempt to introduce censorship? Maybe this was acceptable 'in the good old days' but surely we are now mature enough to allow you to publish opinion papers that fully express the individual's opinions providing they are relevant to the Journal and are within the bounds of decency and legality.

It is also suggested that 'we should change our negotiators'. I believe that it is the duty of our negotiators to represent the views and needs of our members. We should respect the offices held but those who hold them must earn the respect.

The BDA negotiators are representing the views of the many members who are, it appears to me, convinced that the GDC is not working in the best interests of the community and is 'not working with dentists'.

A. Green, by email

1. Baker R A. Cause for concern: BDA v GDC. *Br Dent J* 2018; **224:** 769–776.

DOI: 10.1038/sj.bdj.2018.654

Sense of humour?

Sir, I have very much enjoyed your past two good humoured *BDJ* Christmas editions, and having seen the 'call to arms' for items for this year's, wondered how I (and presumably many others, since there was only one submission) could have missed the same request for your 'Midsummer Madness' edition?

However, it is quality, not quantity, that counts and the Opinion article[1] from Mr Baker certainly fitted the bill, with his wonderfully bizarre examples.

My absolute favourite was: 'The GDC has attempted to cut costs, for example it cut catering costs in 2001-2 by 42%.'

He also references the 'Charlie and Rufus' videos and through your pages, I wonder if their editor, Mr Mike Wilson, could be persuaded out of retirement to do one more episode 'Dr Baker and the ARF solution'?

A. Lockyer, by email

1. Baker R A. Cause for concern: BDA v GDC. *Br Dent J* 2018; **224:** 769–776.

DOI: 10.1038/sj.bdj.2018.655

Oral surgery

Labial frenectomy: Indications and practical implications

Sir, orthodontic and oral surgery departments are becoming inundated with unnecessary referrals from dentists, and sometimes orthodontic specialists, requesting upper labial frenectomies.

The age ranges vary, with some practitioners referring children in the primary dentition, which is illogical. Alternatively, referrals are for patients in the mixed dentition developmental stage with physiological spacing (sometimes referred to as the 'ugly duckling stage' of dental development – a term best avoided for obvious reasons).

The presence of a diastema less than approximately 2 mm may be considered normal at this stage of dental development, with the diastema often closing spontaneously upon eruption of the maxillary canines.

Neither the presence of an upper labial frenum, nor a maxillary dental midline diastema, is in itself an indication for a frenectomy. This is the case even when pulling the upper lip away from the dentoalveolus leads to visualisation of blanching in the palatal mucosa. This blanching is an indication that fibrous tissue from the labial frenum is passing between the central incisors, usually through an alveolar notch in