smile that improves a patient's psychological wellbeing so that they will be keen to have a better general quality of life.[5,6] *This was noticeable with our patient, as the MMT team reduced the amount of the methadone dose. Moreover, smoking cessation was advised to help improve periodontal and gingival health, which has been proven in this case and also during the review clinic. This impacts oral and dental healthcare, and thus general health and psychological and social aspects of patients. We always offer our patients who smoke a smoking cessation programme as a part of dental treatment. The main role of dentists is to improve oral and dental healthcare, which will help to improve other aspects of life.*[5] *Regarding your experience with your patients who informed you that it is easier to give up drugs than cigarettes; this depends on the type of drug they use, dosage and number of years, and also the frequency and number of cigarettes they use.*

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DOI: 10.1038/s41415-019-0515-0

GDC regulation

Tying a knot using water

Sir, a recent article[1] in the *BDJ* reported on proposed research into the meaning of 'seriousness' in the assessment of fitness to practise (FtP) cases at the General Dental Council (GDC). The subject arose from the GDC's *Moving upstream* document[2] in which the GDC acknowledged a need to learn how to improve their ability to assess whether a case is serious enough to warrant a full fitness to practise investigation. The article included quotations from the GDC's head of policy and research programme. Apparently, the research will not define seriousness and will not make a list of serious issues in possible FtP cases. Yet it is stated that a 'framework' for guidance and clearer policy for fitness to practise panels will be devised. It said further that this will provide more information that goes beyond the current provision to decision makers in FtP cases.

However, with the refusal to define seriousness and to list possible issues, how will the GDC and the rest of us know what we are talking about? We will not know and I think it follows that the proposed framework will be empty. If, as reported, this really is the basis of the research the 'results' will be meaningless, like trying to tie a knot using water.[1]

If the people at the GDC who make judgements about seriousness lack knowledge of dentistry, the present poor situation is not surprising. As human beings we make judgements on the basis of analogues or comparisons with that which we have seen or experienced before. If you ask an untrained person to make judgements about things that happen between a patient and a dentist, that person will struggle because they have few comparisons to make. Conversely, a dentist will have had training in dentistry and years of clinical experience to provide a host of relevant situations and comparisons. Judgements made by a dentist would thus be informed and probably more useful and just than those made by an untrained person. Is it not time to employ the obvious resource, ie dentists, to make these judgements?

In a recent unpublished review of the document *Moving upstream*[2] (now submitted to the members of the council of the GDC), I have noted in addition to the above that the problems of the unworkable NHS and the atmosphere of fear dentists endure have been ignored. The GDC offers a continuing state of uncertainty, disquiet and uneasiness for both patients and the dental profession. This prolonged experiment with governance by the unqualified must be terminated soon. Surely it is time to end the torture and install a new governing body?

M. A. Bishop, Guildford, UK

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DOI: 10.1038/s41415-019-0534-x

Oral surgery

Poor antibiotic guardianship

Sir, I read with interest and sympathy the paper by Mackie and colleagues detailing their experiences with referrals for third molar management.[1] It mirrors that of my own department, and that of many others, I am sure.

Osler is credited with the phrase 'listen to the patient, he is telling you the diagnosis'.[2] Whilst he was teaching in the early 1900s, the advice is no less pertinent today. Good history taking will clearly delineate the potential different diagnoses for odontogenic and non-odontogenic pain in most cases, and the characteristic symptoms are detailed by the authors. Such attention to the most basic yet important of skills in medicine and dentistry is constantly overlooked, leading to misdiagnoses that may have tragic effects.[3]

However, I would urge practitioners not to be put off from referring their patients for management of third molar issues. Third molar disease carries a significant quality of life impact, and whilst NICE guidance has become increasingly controversial, the need to refer for treatment should not be delayed, and the reasons for treatment are well defined. I see many patients who have suffered third molar symptoms for years, having been prescribed antibiotics on multiple occasions, without definitive referral for management. To use antibiotics in such a way is poor antibiotic guardianship, as the gold standard for management of third molar disease remains extraction and will continue to be so for the foreseeable future. Needless to say, the prescription of antibiotics for symptoms of TMD simply promotes a deep sigh.

T. Thayer, Liverpool, UK

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DOI: 10.1038/s41415-019-0533-y