Understanding how important outbreaks like SARS, Zika and most recently COVID-19, can spread so rapidly and their transmission curtailed should be of increasing concern for dental providers. In order to have comprehensive discussions with their patients about how infections can be transmitted in an epidemic, dental care providers need to be properly educated. However, very little time is allotted to instructing dental and dental hygiene students on public health approaches to interrupting disease transmission. Given these changes, dental educators should also focus on educating students on the most effective responses and interventions in controlling the spread of infectious disease. This could include an introduction to public health control measures such as environmental disinfection, facility closure, isolation of symptomatic cases, social distancing and health education, along with other approaches. Dental educators need to consider ways to formally incorporate instruction in best practices to prevent disease transmission and control of outbreaks into the dental curricula. In addition, we should also include online content that can provide the needed education to dental providers already in private practice. We have already started on developing these programmes.

B. Laurence, Washington, D.C., USA
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#BeKind

Sir, with a heavy heart I write to you to express how saddened and disappointed I am by the behaviour of some members of our profession. The COVID-19 pandemic has undoubtedly shaken and unsettled us all in every aspect of our lives. We are facing a global crisis unlike anything many of us will have ever faced before, and hopefully will never have to face again. Arguably, the pressure on our NHS has never been greater. These are truly difficult times for all. It is for that reason, that, for a moment, I felt ashamed to be part of what I considered to be an honourable profession, when I saw my fellow colleagues posting derogatory, defamatory and disparaging comments about our senior leaders on various online platforms.

COVID-19 is not only threatening our physical health but our mental health and livelihoods too, and naturally during such

unprecedented times the profession will look to our senior leaders for guidance and reassurance. It is not for me to comment on the timeliness or effectiveness of such guidance, but I must say I find it appalling that we can call ourselves professionals, regulated and governed by professional standards of practice and behaviour, but participate in what is essentially 'internet trolling' or an online 'witch hunt' the moment uncertainty arises.

My call to arms for the profession is this: let this be the time that dentists and DCPs come together for the NHS to fight this battle with our medical and nursing colleagues. Let us use this opportunity to show just how powerful, committed and skilled we are as a profession. Do what you can in your regular clinical setting, and when you can no longer do that, do what you can in your community. Let's use this as an opportunity for NHS dentists and dentistry to be seen and treasured for the value it truly holds.

We are all under immense pressure, our leaders included, so let's do what we can, and above all #BeKind.

F. Oluwajana, Manchester, UK
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NHS recruitment

Contract reform and funding

Sir, the letter from Hussain, Thomson and Norfolk¹ about recruitment and retention was an interesting read. For the past four years I have presented oral evidence to DDRB on this very concern, only to be faced with evidence submitted by NHS England and others that there is no problem, with 'dentists willing to tender for contracts'.

I agree with their summary that the worst problems in rural areas are extending across every English region, but the major reasons are not addressed in the letter. It is not that certain areas cannot encourage local school and college students into dentistry – indeed we have the highest number of dentists on the register perhaps of all time. The problems lie with the failing 2006 contract, the lack of flexibility within NHS England to adapt to support contractors and dentists struggling with the system, and the fact that my younger colleagues are no longer wedded to supporting a failing NHS dental service.

The applications at dental school remain remarkably buoyant and whilst it's always a good idea to go into educational

establishments and encourage the potential dentists of the future, that alone will not resolve the recruitment and retention issues we see worsening.

East Anglia like the rest of England needs contract reform and a well-funded service for patients; that might solve the issues of recruitment and retention.

E. Crouch, Birmingham, UK

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Occupational health

Survival of the fittest

Sir, overwhelming evidence, both clinical and anecdotal, affirms that dental professionals are especially vulnerable to musculoskeletal disorders (MSD), particularly those that affect the neck and back region. Literature continues to confirm that repetitive and prolonged actions, whilst employing a static, seated position, prove to be conducive to experiencing joint fatigue, stiffness or definitive pain.¹ Such experiences are a universal concern for dental professionals and are greatly emphasised during undergraduate training.

Whilst undergraduate dental education involves learning about the complexities of the human body, seldom attention is placed on the complex interaction between our anatomy, mental state, and pain perception. Although 90% of back pain has a non-specific cause, high rates are experienced amongst those with high stress levels or mental health concerns.² Therefore, more attention needs to be given to the fact that such psychosocial factors can severely affect the risk of developing MSDs.

Indeed, the evolution of dental technologies has enhanced the practising experience for the dentist. Optimally fitted loupes in conjunction with the use of a saddle chair allows professionals to adopt a certain posture that allegedly reduces the risk of back pain. However, emerging evidence stipulates that the 'perfect posture' fails to actually exist.³ Therefore, it is critical that attention is directed towards various other strategies.

Weight management, improved mental state, and immune function are all beneficial consequences of regular physical activity. Therefore, physical exercise, particularly

cardiovascular exercise, can significantly reduce the risk of MSDs.³ Thus, the rationale 'survival of the fittest' truly becomes apparent within the dental profession. Equally, stress management is vital. Literature affirms that our stress levels can affect pain perception; consequently, adopting strategies early on in our careers to combat potential MSDs is critical.

MSDs have an inherent role within dental experience. Whilst the rationale for adopting good posture and practising with magnification remains, I feel that a greater emphasis should be placed on our physical strength and health, particularly during our undergraduate training, in order to confront the issue that MSDs can have on our working lives.

M. Butt, London, UK

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Dental history

Dental ties

Sir, thank you for publishing *Unidentified dental tie at BDA Museum* (BDJ 2020; **228**: 8). The tie featured in the piece has been identified – Senior Crown and Bridge Staff Group at the Eastman Dental Hospital and Institute, and the response to the item has resulted in many more ties being pledged and donated to the BDA Museum Dental Tie Archive, some coming from as far away as Australia and Canada.

The purpose of this letter is to explain to readers that the focus on ties is because 'club' ties, now going out of fashion, are 100 years old this year – the first 'club' ties being regimental ties worn as a badge of honour following World War I. Time and opportunity permitting, attention in the future may turn to ladies' dental scarves, unisex lapel pins or dental themed cufflinks. I am certainly not, in any way, being misogynist in presently limiting my efforts on behalf of the BDA Museum to hopefully

creating the world's largest collection of dental ties.

In the meantime, many important gaps remain in the Dental Tie Archive, albeit that the Archive now comprises close to 100 different ties which, in all probability, is the 'tip of the iceberg'. Also, I am anxious to identify and, if possible, acquire an example of the first dental tie, the oldest tie in the Archive at present being a Manchester Dental Hospital tie dating back to the 1930s.

With special thanks to the 26 donors to the Dental Tie Archive to date.

N. Wilson, London, UK

<https://doi.org/10.1038/s41415-020-1492-z>

Dental architecture

Ratio decidendi

Sir, successful outcomes in dentistry, law and architecture are frequently achieved by balancing the proportions and the influences of competing parts and contributing parties. The golden ratio in dentistry and the scales of justice in law serve to guide and emphasise this.

In 1964, the architect Sir Denys Lasdun did not ask physicians what they wanted, rather, what they did.¹ Their partnership created one of London's most important post war buildings for the Royal College of Physicians in Regent's Park, today a Grade 1 Listed masterpiece.² A contemporary influence of Lasdun was the architectural polymath Sir Hugh Casson. In partnership with Neville Conder and David Hindley-Smith (the first GDC Registrar), three years after the 1956 Act enabled dentistry to be its own master, their building was ready. The influences of Sir Basil Spence and Le Corbusier could be seen throughout, their fittings and furniture modernist and iconic.

With his own hands, Casson purposefully carved a pattern into the foundry sands, pouring the iron to cast the doors to 37 Wimpole Street.³ Playfully inspired by the structure of hydroxyapatite, a hexagonal Hearing Chamber for dentists arose in Marylebone's medical heart, solemn judicial function following successful concrete form. For over 50 years, judgements were delivered beyond any reasonable doubt, the sincerity of proceedings reflected in Casson's murals and the portraits of GDC presidents, the democratically elected dental leaders.

The sentiment and symbolism both of and within this award winning building was not lost on those appointed to take control and implement the 2008 Health and Social Care Act, which then lowered to a civil standard the level proving misconduct and with that, a striking rise in disciplinary cases followed. By 2014, Casson's work was destined for destruction in the hands of an executive who demanded, then got what they wanted, with little justification for what they did.

Their designers tore the building's heart out, but when its presidents' portraits were taken down, its soul was lost. Covered in paint, cement-dust, their frames twisted and broken, they were rescued, gathered up and placed in the BDA museum.⁴ Coming to learn of their value, the GDC executive enforced copyright restrictions and their loan in perpetuity.⁵

The destruction of a building destined to achieve a listing like Lasdun's didn't halt the industrial level of hearings taking place in external processing facilities. In temporary surroundings bereft of that gravitas conferred by Casson, the task of balancing probabilities would be problematic. In 2020, hearings returned to Wimpole Street and committees could more confidently measure rational decisions balancing them against persuasive opinion. While the authority of the original building is gone, we should remember that while it stood, huge changes were made to the regulation of dentistry. Historically those times proved to be professionally significant. We believe the confluence of dentistry, law and architecture to be an important one. In 1959 Casson successfully united two professions. Given today's relationship between dentistry and its regulator, further consideration of that period is surely needed.

J. Laszlo, London, A. Riley, Sevenoaks, UK

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