Letters to the Editor

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Priority will be given to letters less than 500 words long.
Authors must sign the letter, which may be edited for reasons of space.

NCAS CONTINUES

Sir, the Department of Health in England, in its review of arm's-length bodies – *Liberating the NHS: Report of the arm's-length review* – announced its intention to abolish the National Patient Safety Agency (NPSA) as an arm's length body.

In addition to its patient safety responsibilities and commissioning confidential enquiries in the field of patient safety, NPSA manages two distinct operating divisions: the National Clinical Assessment Service (NCAS) and the National Research Ethics Service (NRES). I thought, as Associate Director for Dentistry at NCAS, it may be helpful if I wrote briefly about the recommendations in respect of our service. In summary, NCAS continues into the future and will be expected to work towards self-funding over two to three years. We have undertaken some work on how our business model will have to adapt to reflect the changes in public sector policy and to meet the needs of the diverse professions, jurisdictions and sectors we now serve. In the interim, it is likely that we will move to a hosted arrangement to enable this work to move forward.

A central driver for NCAS is the continued need for our expertise as the reforms to professional governance move forward, indeed the past year has seen NCAS' busiest times in recent years.

NCAS at present remains free to access at the point of delivery and looks forward to continuing to work with dentists into the future.

J. Brooks MBE
London
DOI: 10.1038/sj.bdj.2010.889

A REASONED APPROACH

Sir, the GDC should adopt a reasoned, pragmatic approach to the issue of the 'Dr' title rather than trying to address a problem where there is none.

The title 'Dr' is used by almost all dentists throughout the world; this is because many countries award a doctorate as their primary dental qualification. When I am abroad I am always accorded the title 'Dr' and people have no difficulty with the concept.

In this country, graduates of medicine and dentistry are usually awarded a bachelor's degree. No one has suggested that we are any less qualified or capable than our overseas colleagues; in many cases the reverse may be true.

Our medical colleagues have established their use of the courtesy title 'Dr' through common usage over many years. Dentists are now seeking to do the same and, in my experience, almost all new dental graduates are doing so and have been for some time.

A colleague recently joined our practice and she uses the title 'Dr'. We decided, therefore, that all the dentists at the practice would now do the same. This has not caused any confusion with our patients, even those new to the practice. Many have expressed the view that 'it's about time' and entirely appropriate.

The use of the title allows female practitioners to disguise their marital status if they so wish, an important factor in the very personal relationships that our patients can often have with us.

Quite frankly, I find the view that I might seek to enhance my professional status by inferring that I am medically qualified very insulting. I assume that no one feels our medical colleagues might do the same by claiming a dental qualification.

Holders of a PhD, whether dental or not, presumably represent a similar 'risk'. Is this currently a significant problem? Where is the evidence base?

We demean our profession if we think our patients would prefer to have their dental treatment provided by an individual who has anything other than dental qualifications.

Provided safeguards are in place to deal with misrepresentation by all dental care professionals, the GDC should allow our profession to move forward and join the rest of the world in the twenty-first century, not push us back into the nineteenth.

To quote Keith Marshall, 'doctoring does not stop at the mouth'.

A. J. Walley
Wantage
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OUT OF THE BOTTLE

Sir, it is amazing that, after all these years, the GDC is still smarting from being persuaded to amend their guidance to allow dentists to use the courtesy title 'Dr' back in 1995.

For the sake of our younger colleagues who may well have been using the title since they qualified it might be helpful to relate the history of this issue. During the 1990s an increasing number of dentists were openly using the title 'Dr' in defiance of the GDC's guidelines set out in their 'Red Book'. By the time the GDC debated this issue in November 1995 (the second time they had looked at the matter that year) so many dentists were openly using the title that the GDC had to accept that it would be impossible to take action against them all and voted to remove the sentence which precluded dentists

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using the title 'Doctor' in relation to their practices.

The Council's position then was that use of the title 'Dr' would confuse patients and it appears to be unchanged. Rather than confuse patients, I would maintain that use of the title 'Dr' helps patients understand the dentist's role as leader of a team of dental care professionals. With around 50% of dentists graduating being women, their use of the title 'Dr' helps patients distinguish them from the hygienists, therapists and dental nurses who are also involved in their dental care. It also helps patients understand the depth of knowledge and understanding that a dentist has acquired during their years of training.

A whole generation of dentists will have been using the title 'Dr' since they qualified and will be somewhat bemused by the fact that the GDC is still of the view that they should revert to being 'Miss', 'Ms' or 'Mr' so as not to confuse their patients!

I think it highly unlikely that dentists using the title 'Dr' will cease to do so no matter what the GDC might decide at the completion of its consultation. Once the genie is out of the bottle it is difficult to persuade it to return!

M. Wilson
Esher

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MASOCHISTIC PLEASURE

Sir, it cannot be a massive surprise that the Government has withdrawn the necessity for the DDRB to assess and make pay recommendations for GDPs in England for the next two years as this was mooted during my time as Chair of GDPC and during the tenancy of the previous chair of DDRB. In fact DDRB itself questioned whether it had a future role relating to GDP dentistry in England and Wales.

The market forces aspect of tendering for contracts in England effectively negated the recommendations for GDPs because the price per UDA tends to be driven by the competition to get UDAs to be able to provide NHS services. The recently published, outdated, figures which do not wholly reflect the effects of the economic downturn will simply add weight to any governmental argument for minimal/zero uplift in pay. With the DDRB no longer there to balance the arguments, this will allow the Department of Health free reign to make whatever adjustments it feels it can with their usual take it or leave it attitude and, of course, backed by the Treasury.

In 2007 we argued that the role of DDRB should be retained as it is important. Even if the Government chose to ignore their recommendations at least the profession would have an independent overview balancing the arguments being presented by the profession and the DoH.

DDRB's recommendations could be discarded, as they have been in the past, but we would have had the benefit of an impartial view as to what the uplift in pay *should* have been - a sort of masochistic pleasure which the profession could enjoy debating.

However, once this role is lost for two years it is almost impossible to believe that it will be revived given that the PCTs' functions are to be placed in other arenas and the medics will administer the financial arrangements for their colleagues. Market forces will be applied to the provision of healthcare in all aspects. Will patients benefit? On past performance it is unlikely but we shall have to wait and see.

L. Ellman
By email

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REDEPLOYING RESOURCES

Sir, we read with interest the paper by Landes and Jardine (*BDJ* 2010; **209:** E3) and totally agree with the authors in that the methodology is a useful tool for primary care organisations so as to improve equity of service delivery.

However, it would be important to emphasise one point from that paper and that is: 'The data suggests that dental practices in the more deprived areas tend to be smaller and that merely increasing the practice size will not necessarily result in higher proportions of patients attending from deprived areas'.

We analysed data from a peer review project undertaken by nine dentists in South Wales in 2006 using a similar methodology.[1] Figure 1 demonstrates how location of practice does not necessarily reflect the deprivation profile of the area.

Even in area 1 where 75% of the population is considered to be deprived, only 45% of the practice population is defined as deprived. Therefore increasing the size of this practice without addressing the type of patients the practice is caring for would not improve equity. Similarly in area 2 where the area profile is less deprived the population attending the practice is biased towards those considered to be non-deprived.

This is an important point for PCOs to consider when allocating their resources. Practices that are located in affluent locations may have practice deprivation profiles which may not necessarily reflect the affluent area, particularly in urban situations. In these situations PCOs could penalise practices in affluent locations (servicing deprived populations) and reward practices in deprived location (servicing affluent populations) thus (re)deploying resources inappropriately.

W. Richards, G. Higgs
By email

1. Richards W, Ameen J, Higgs G. Adapting to change: dental prescriptions. *Br J Healthc Manage* 2008; **14:** 500-504.

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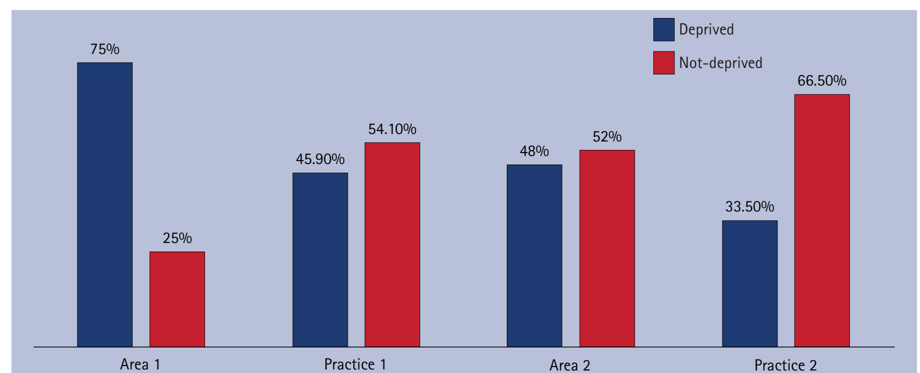

Fig. 1 Area and practice deprivation profile

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