they feared job losses or other consequences we will not know unless a robust survey is carried out. The London LDC 100 will have been a small group who were brave enough to raise the matter, in all likelihood the real figure will have been considerably higher in the London area.

As a result of this injustice, for the first time working for a corporate became more attractive for associates as a whole. If nothing is done about this minority (although large) number of profiteering NHS principals, there will be dire consequences for respect, cooperation and the future of the dental profession. The NHS has a duty to the tax-payer to ensure financial aid is distributed in a fair and just manner. In addition, I believe the NHS, GDC and BDA have a duty to prevent injustice in the profession. After all, this will not be the last pandemic our country faces. At a minimum I would advise that changes be made to NHS contracts to make it a requirement to follow NHS guidance, particularly when financial aid is being distributed, the GDC to act with severe consequences when registrants are threatened or blackmailed and the BDA to raise this matter at the highest level.

S. Nazemi, via email.

The choice is ours

Sir, thank you for your article in *BDJ In Practice* last month in regard to NASDAL's figures on associate income.[1]

The figures that you quoted are the physical realisation of the failure of associates to make a good income. The blame can be split between the corporatisation of dentistry, the rise of Dental Law Partnership (and others), the rise of probity by Business Services Authority and government's insistence on more for less.

Since qualifying in 2000, I grew up in the gritty world of family run NHS practices in which every dentist sweated their day list of 40 to 50 patients. Even the principal would bash the patients out, even though far more of his percentage were private. In essence, everyone earned about the same, it was just that the dentists with the heavier private lists didn't have to work as hard. It was tough but the income was immediately into the £100,000 within a year or two under near 100% NHS. Little concern was given to getting sued or dragged in front of the General Dental Council. We didn't hear from the BSA, only the occasional visit by a dental officer (RDO) who joined for a coffee and talked through the patient list and perhaps saw a patient or two. Pay was little per item but with quick working and getting as much done in one appointment, the money flowed. The important factors were patients getting what they needed and the associates getting a sense of worth by the end of the day.

As time evolved, the family practices sold out to corporates. *MyDentist* and *Bupa* started to take over the world, run by managers who were only interested in profit and loss accounts and minimising expenditure. The actual needs of the patient or dentist started to fall away as the business bottom line gained focus. The amount that they would pay associates fell from a fair 50% to 45% or less.

DLP got developed and realised the cash cow that is Dental Protection and the Dental Defence Union. Dental notes grew from a quick couple of sentences between patients (that took seconds) into the reams of pages that the lawyers expect to see now that take a good 10 minutes to write. The rise of statements like '*if you don't write it down, it didn't happen*', only to be thrown on its head by the use of templates now which result in statements like 'if it's written down, you probably didn't do it'. It all took time – time that a busy and profitable NHS practice didn't have.

The BSA got on the bandwagon as well. As notes became computerised and claims started to be sent by EDI it became easier for probity computers to track claims. Local health authorities started to get monthly reports on the claims that 'their' dentists were making and they started to see trends and means of making it harder for each claim to be honoured. Out the window went the 'professional honesty' of the associate and in came the 'guilty until proven innocent' attitude of NHS managers. Claims now took longer to justify and make sure that all the relevant boxes were ticked for fear it gets rejected.

The GDC felt that they needed more to do. The number of cases ahead of them was few. The protection of the public was being managed through the diligence, professionalism and care of individual associates. The need to advertise for complaints and search for further problems when a simple issue was raised became common (the going round the car measuring tyre depth and lights working, when the vehicle is pulled over for simple speeding). This got further worsened as NHS PAG and PLDP panels were introduced to further sentence associates who had been brought in front of the GDC. Double punishments become common. Activity in practice now had to be reflected upon 'how would this look if the GDC reviewed it', this all meant more time was taken with each patient and all problems are sorted as soon as they arise.

The last factor is the growing intelligence of young dentists. The older dentists are a bit thick. In my late 40s I appreciate that I got into dental school with a B and 2 Cs. Now it is 3 As and extra-curricular activity. The students are seriously clever and not grafters. The mentality of the dental student is to have a work life balance, work less and earn less. Why graft in practice to earn enough to buy a practice when the cost of a practice is unaffordable? Why become a businessman and buy 3 practices with money borrowed from the banks, turn to the dark side of dentistry and sweat associates to earn the money for you while you see just private patients. Family NHS practices? Gone. Unviable.

Associates have to work as if they were treating private patients, even though they are NHS. The standards set by DPL, GDC, NHS PAG and corporates mean that grafting through 40 to 50 patients a day is impossible. If an associate wants to earn good money they have no option but to go private.

What do corporates do when they don't have NHS associates anymore? Increase oversees dentists? Go private themselves? One thing is for certain, associates can't earn as they used to. Do we accept the reduced income, work more hours in the day or go private and charge a good hourly rate? The choice is ours...

T. Hancock, GDPC associates group rep, via email

Reference

1. Westgarth D. NHS and private principal net profit: What do associates think? *BDJ In Pract* 2022; **35:** 17.