some unrelated allegation. This can already be done under existing rules. It is similar to the FP17DC procedure where paragraphs 4 & 6 of the terms of service are only investigated in conjunction with alleged breaches. This has not prevented the FP17DC procedure being one of the most ignored regulations in mixed practice.

Historically, the only experience of practitioner enforcement is either through the NHS disciplinary procedure or the GDC. Even those readers who might have had first-hand experience as professional members of these bodies cannot imagine the public expenditure or ARF management costs. The initial correspondence, the disclosures, the adherence to set procedures, time-bars, postponements, arranging dates, agreeing to and preparing a report are all an administrative nightmare. By definition, there would also have to be a mechanism of appeal. The OFT wisely side steps the issue of who pays.

Preparing the legal framework will be difficult. First, there has to be a set of codified rules. By definition, these will have to be written and refined by lawyers. Although the Interpretation Act 1978 will apply, there still will have to be some poor chairperson who will have to make a final decision on what the words actually mean. Just consider the definitions of:

- 'Relevant services'
- 'Clearly displayed'
- 'Treatment plan'
- 'Prominently'
- 'Itemised costing'.

Readers have only to remind themselves of 'dental fitness' and 'oral health' to think of the potential minefields.

The last in the transparency section is that private dentists 'refer existing patients who want NHS treatment to a relevant body if they stop offering NHS treatment'. Although the recommendation is not onerous the wording is muddled and shows the OFT's lack of understanding of existing terms of service. Fundamental to an NHS registration is that there is no choice until a patient is de-registered. Paragraph 3.6 of *Maintaining Standards* already covers the responsibility of a dentist to explain clearly to the patient the nature of the contract. Until further legislation spells out the management of such referrals, it could be simply interpreted as giving the telephone number of an access centre.

On the matter of fee surveys, the GDPA and CODE come out well. Current BDA policy is still one of obscurantism. The chair of the BDA's private practice committee said: 'We felt that there was a potential for a survey to have a depressant effect on fees'. Their last survey was published in 1997. Currently, *Dentistry* magazine (in association with *Private Dentistry*) is carrying out a fee survey.

The OFT report is clearly of the view that dentistry is a commodity and not a service. Their view is that a treatment plan is a homogenous product that is either provided under the NHS or provided privately. Furthermore, a practitioner must commit himself to the distinction in advance of the consumer's expressed wishes. The corollary of this must be that all consumers are clones and have identical dental needs. Underlying this *reductio ad absurdum* is the often forgotten right of a practitioner to choose who they will accept as a patient and under what contract. There are whole ranges of non-clinical factors on which a practitioner will intuitively decide how they will offer their services. It is difficult to imagine a position where a practitioner can be legally bound to straightjacket themselves into either a NHS or non-NHS contract before having the opportunity of meeting the potential consumer.

On the present evidence, there is little in the transparency section of the OFT report that could lead to the framing of precise and unambiguous legislation concerning prices and services. It is unlikely that we shall be following the Dutch government's policy where there are maximum fees for private dentistry. For the present, the Consumers Association will have to remain satisfied that private dentistry will still have to be supported by good ethics and good communication. Both also happen to be good business. ID