am pleased to see that the executive officers of the BDA are actively attempting to hold the GDC to account.

As an individual dentist who has lost all confidence in the GDC and is disgusted by recent events, I call for the Chief Executive, the Chair of Council and those responsible for approving the unlawful action to resign.

J. Wilson, Cardiff

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ORTHODONTICS

Causes of malocclusion

Sir, in response to the letter from S. Rudge[1] (representative of the British Orthodontic Society – BOS), my concerns are that:

1. The orthodontic profession does not yet know the causes of the malocclusion
2. Whilst the profession provides orthodontic therapy for approximately 30% of the population, including in some cases major surgery, and many with long-term retention consequences, certain orthodontic therapies may not be evidence-based
3. In not doing everything we can to further the debate on the aetiology which underlies the work we undertake for our patients, we fail to honour our patients and our privileged, self-governing status of the profession.

S. Rudge helpfully notes five events in recent times at which the BOS has supported discussion on other subjects. I commend it for this, its continued support for these exchanges and evidence-based medicine, and experience which should be made available to the general dental profession; those practitioners who in good faith refer their patients to our specialism.

The GDC describes its role as *inter alia* '...to regulate in the interests of patient protection, not to review scientific evidence or bodies of scientific opinion outside the context of a specific complaint of the kind set out above'. Whilst it is appropriate that a regulatory body does not become involved with clinical arguments, the GDC did sponsor a debate on the aetiology of malocclusion in 1936. Therefore, it may be apposite to debate the subject again through their auspices. We could then reflect on the considerable experience, research and advancement in our profession and test whether these give new light to our current, relatively limited, understanding. To support this I make available copies of this and other discussions through an open forum (www.orthotropics.com\debate). I hope that this is considered a constructive contribution to the debate and would welcome contributions from all.

Given the gravity of this situation, could the GDC give an opinion as to whether a debate on this issue would be in the interests of the profession and public at large?

M. Mew, by email

1. Rudge S. Engaging fully. *Br Dent J* 2013; **214:** 430.

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Orthodontosis and orthodontitis

Sir, there is now a significant body of literature that questions the basis of current orthodontic diagnosis and treatment goals and I propose the diagnostic terms of 'orthodontosis' and 'orthodontitis' to address these deficiencies. Emerging literature exposes the lack of evidence for the Angle's classification of Class I (ideal), II or III since there is no verifiable scientific validity that ideal occlusion provides significant benefits in oral or general health.[1–4]

Clinical observations after two decades of orthodontics practice lead to proposing the establishment of a new classification for malpositioned teeth based on the clinical morphology and appearance of the alveolar bone and ridge.[5] Orthodontosis, defined as the non-inflammatory