BSGDS
Newsletter

2012

www.bsgds.com

President's *Report*

This year's report must begin by paying tribute to Phil Lang, our immediate past President, who sadly passed away in March. Phil was a founder member of BSGDS and has given many, many hours of his time to the Society, most recently as Treasurer and then as President. He fulfilled these roles with great humility and steadfastness, particularly in his Presidential year when he was battling with his illness. The Society owes him a debt of gratitude and he will be sorely missed. I am certain all members would wish to join me in sending our sincere condolences to Rosemary and his family.

This year could be a momentous one for the Society. Attendance at the Annual Conference has fallen in recent years and despite offering membership to a wider circle, membership is dwindling. Perhaps with the formation of the Faculty the Society's original raison d'être for existence is no longer relevant. We must either find a new direction enabling us to enthuse a new membership or we will die. There will be motions at the AGM to either wind up the Society or to continue the Society with a new constitution and new rationale. The committee is working hard by looking at different options and the concepts of professionalism, ethical standards

and the foundation of a College of Dentistry loom large in our deliberations. The current Dean of Faculty, Russ Ladwa, has agreed to assist us in these deliberations when he leaves office. A closer relationship with the FGDP (political wing?) is one option. If any member wishes to contribute to our deliberations please email me at chrisjthedentist@hotmail.co.uk.

In view of these matters, of considerable importance to all of us, it would be great if as many members as possible could attend the Annual Conference and study day at **The Palace Hotel, Torquay from 5-7 October.** The study day will be sponsored jointly with the Faculty. The speakers will be Prof St John Crean and Kevin Lewis and professionalism will be a key theme.

Application forms are now on the website-please book ASAP. Additional application forms are on the back page of this magazine.

Finally, may I congratulate yet another BSGDS stalwart, Trevor Ferguson on being elected Dean of Faculty to replace Russ.

I hope to see many of you in Torquay in October.

Chris James
President, BSGDS

Inside this edition:

A few words from the Editor…

We are all agreed that the BSGDS is a unique society. In this issue Trevor Bigg and Steve Perry make cases for the Society to continue and Edgar Gordon and Paul Downes for the Society to close. We invite members to make their voices heard by getting in touch with Chris James or putting your view on the website forum. Please interact so that we have a broad view of the Society's wishes.

Major moves within the profession and business of dentistry are being voiced both by the profession at large and at the Faculty of General Dental Practice and we have invited eminent speakers, Kevin Lewis and St John Crean, to address the annual conference in Torquay on 6th October – where these issues will be discussed. **Make sure you come to the annual conference in Torquay 5-7th October – see later.**

Our members have been out and about. Since the last issue, Rash has organised a trip to Vietnam and members have been with the AOG to India, Kenya, SA and Tanzania.

Chris and others have paid tribute in this issue to the sad passing away of a great stalwart within our Society, Phil Lang. He was a founder member, a treasurer and our immediate past president: his presence and words of wisdom will be sorely missed.

Included in this issue are reports from those whose research we have supported, Tom Dyer and Bawinda Dawett, both of whom have been looking at skill mixes in the delivery of dental care. Their work has shown some interesting concepts that we need to consider in relation to delivering care by DCPs.

Faculty has issued new guidance about Anti-microbial prescribing including to children and its launch is highlighted here together with its course on treating the vulnerable child and adult.

I hope you enjoy this issue: I am aware that it is a long time since a copy appeared, which is regrettable but unavoidable – I hope it adds to its value!

Auriel Gibson
Editor

New Antimicrobial Prescribing Standards

The Faculty of General Dental Practice (UK) has launched a new standards book:

Antimicrobial Prescribing for General Dental Practitioners

This book has been designed to help general dental practitioners with prescribing antimicrobial agents. This book expands on and updates guidance provided in the previous book (*Adult Antimicrobial Prescribing in General Dental Practice*) including for the first time, dosage recommendations for children.

> *"This is a very timely book. I was recently at a talk on the non surgical treatment of periodontal disease, where the speaker talked about the over-prescription and misuse of antimicrobials. As a profession we need to ensure that antimicrobials are only prescribed when necessary and in the right dosage."*
> *Rus Ladwa*

The authors have reviewed all of the available data and guidance, and consulted widely with professional bodies and specialist groups to provide a consensus on best clinical practice. The guidance gives clear, simple and practical advice on when to prescribe, what to prescribe, for how long and in what dose.

Editor Nikolaus Palmer said:

> *"This book was produced to complement the BNF and provide general dental practitioners with an 'in surgery' easy to read evidence based guide on the management of dental infections. The authors hope that the advice provided in the document will promote appropriate antimicrobial prescribing in primary care and improve the standards of patient care."*

Stunning line-up
Stunning location
Stunning people who go!

BSGDS ANNUAL CONFERENCE 2012

5-7 OCTOBER

THE PALACE HOTEL TORQUAY

From dinner on 5th to
Breakfast on 7th October

Lecture Day, Saturday 6 October 2012
in association with South West Division of the Faculty of General Dental Practice (UK)

- ***25 acres of beautifully landscaped gardens extending to the sea***
- ***one of the largest and most prestigious hotels in Torquay***
- ***impressive indoor and outdoor sports and leisure facilities***
- ***notable heritage as the home to the Bishop of Exeter***
- ***one of the best located Devon hotels to explore the English Riviera***
- ***Why not make it a late break and stay a few extra days (to recover from the time it will take to get there!)***

www.palacetorquay.com

Booking: forms in magazine or download from website: **www.bsgds.com**
Enquiries: chrisjthedentist@hotmail.co.uk (heading **"BSGDS Lecture Day"**).

Booking form on page 23.

Kevin Lewis
– The Professional in General Dental Practice

Professor St John Crean
– Medical Aspects of GDP

Professor St John Crean, Dean of the School of Medicine and Dentistry UCLAN and Robert Bradlaw advisor in Oral and Maxillofacial surgery at the Royal College of Surgeons of England. His themes will include medicine in dentistry and additional medical responsibilities that may be introduced for GDPs in the future.

Kevin Lewis, Dental Director of Dental Protection is an extremely well known speaker. He has been invited to discuss a wide range of topics, which may include the professional in today's practice, their responsibilities, risk assessment in treatment planning, CQC, and the establishment of a College of Dentistry.

The lecture day will be open to all members of the dental team.

BSGDS Spring Scientific Conference 2012

Vietnam

An evening flight is always civilised and Singapore Airlines proved very comfortable with their delightful hostesses bringing Singapore Slings to while away the long hours to the magnificent Singapore Airport, where we changed for Saigon, alias Ho Chi Minh City. The ride from the modern airport to the splendid Sheraton Hotel allowed our first glimpse of the very green and wet countryside and the city streets, filled with mopeds, pouring through like platelets in a multimedia guide to the bloodstream. A brave few wandered the streets that first night to find a vibrant modern city with fascinating traditional areas and cheap beer. Friendly smiling people encouraged you to visit their shop or bar and men, squatting on low stools, proudly displayed photographs of their sisters on their smart phones!

The hotel breakfast encompassed every culinary style known to man, particularly Asian dishes, and exotic tropical fruits. Then we bussed to a preserved section of tunnels that the Vietcong used in the wars against the French and later the Americans and saw the underground hospitals and meeting rooms. There was an opportunity to fire some of the weapons made famous by the conflict and to view grisly man traps consisting mainly of bamboo spikes at the bottom of concealed pits. The next stop was the "Reunification Hall" in Saigon which displayed tanks and aircraft from the American War and featured gruesome pictures of American atrocities against the kindly communists. Appetites thus whetted, (or perhaps we are rather too good at putting such images into the delete file), we ate at "Monsoon" – the first of many fantastic meals. Vietnam is worth visiting for the food alone, not only the local cooking, but restaurant styles from all over the World.

The trip to the Mekong Delta showed us the incredibly fertile "Rice Bowl" of the country; they can grow four or even five crops in a single year because of the warmth and the rain. We visited in the dry season -a relative term as we had many showers – but it was so warm that it didn't really matter. So much to see and eat! We cruised the river around the town of Cai Be seeing floating markets, boats laden with wholesale produce, and stopped at villages to see rice paper and 'popped rice' being made. For lunch we were rowed on sampans up a smaller channel to a tropical garden with open pagodas where we were plied with exotic and delicious dishes.

Our guide throughout the stay was Jonnie who was perfect in the role and managed not to lose anybody – permanently. His merry cry of "Sticky rice" was the call to assemble. He supervised the drivers and the bus boys and smoothed our path into all the hotels and airports but had a slight penchant for dumping us for long periods at retail outlets where commonplace holiday souvenirs such as ten foot marble statues could be bought.

Hoi An, a traditional town with full awareness of the needs of tourists, was the highlight of the trip for many of us. The hotel fronted miles of unspoilt beach and had all the trimmings of a luxury seaside resort. Here we chilled out to the sound of chinking ice on its way to our sun loungers and the gentle swish of the waves. In support of the local economy, and to ease pressure on the ladies, the gentlemen willingly carried the laundry over the road and entrusted it to the tender care of Fifi who also offered massage. Meeting colleagues "over the road" was always prefaced by a full explanation as to why they were there! Largesse to the laundress seems very much in keeping with the ideals of the society. Hoi An was lit up with coloured lanterns at night and there were endless shops and stalls where everything from carved coconuts to silk dresses and jewellery could be bought. "Mango Mango" provided perhaps the most memorable meal of the trip with course after course of tradition 'al Vietnamese' seafood.

But the Conference was what we came for and the esoteric agenda matched the exotic surroundings. Neesha Patel gave us a view of traditional oral hygiene practices in India and had pragmatic ideas about incorporating these beliefs into Western dentistry. Helen Jones' presentation made us think twice about our natural scepticism towards cures we don't understand with examples of how correction of jaw position and occlusion can help those with unexplained weakness and disability. James Hardy posed the question of whether improving oral health made forensic identification more difficult before Joseph Xuereb gave a very interesting overview of the health care systems of European countries concluding that there is no perfect system. Our brains thus stimulated, we returned to the beach bar to subdue them again.

Next stop was Hanoi with a somewhat surprising introductory talk on the bus about the shortcomings of the Northern people – not something you get very much from the conductors on the East Coast Line in the UK! In truth, Hanoi was a bit dingy, overcast, and the people didn't smile much. First stop was the infamous Hoa Lo Prison,

Trip to Vietnam March 2012

the “Hanoi Hilton”, where Vietnamese freedom fighters had been treated very badly in French colonial times as evidenced by a large guillotine but, fortunately, captured US airman had been well cared for as evidenced by pictures of happy, smiling Americans indulging in leisure pursuits. The museum of Ethnology was probably another compulsory stop but there were some interesting traditional buildings in the surrounding park and a water puppet show that affirmed the decision not to pay to see one for several hours. In the evening the city was alive with young people on mopeds, coloured lanterns, and intriguing markets.

Halong Bay is an amazing sight with thousands of limestone islands rising vertically from the sea. We boarded our luxury junk to eat another fabulous seafood lunch as we cruised. The cabins were wood panelled and en-suite, while the upper decks were ideal for partying, and of course, early morning Tai Chi. During the cruise we visited a floating fishing village and huge limestone caves. We had the boat to ourselves, with extra accommodation for undesirables on a smaller boat that shadowed us, and the whole atmosphere was magical.

One last meal in Hanoi was arranged at an Indian restaurant which lived up to the previous standards of marvellous dishes before an early start for the flight home. But not before we paid a visit to Ho Chi Minh, now, sadly, deceased, but embalmed and mounted in his own Mausoleum. The queue to file past him had all the excitement and anticipation of a Disney line, the side shows being smartly uniformed, goose stepping guards, and entrancing parties of tiny Vietnamese school children who crocodiled along holding the back of the shirt of the TVSC in front. After a quick tour of HCM’s modest dwelling in the grounds of the presidential palace, by-passing the exhibition of his used cars (sic), and continue waiting for Arrif and Karim who took their last opportunity to be late, we headed for the airport.

Vietnam is not the first country that comes to mind for a pleasant break and conference but it is amazing how many people have been there and can’t praise it enough. Rash and Nora numbered amongst these and, with customary generosity and energy, planned and executed a superb trip. A large contingent of the BSGDS and AOG cannot thank them enough and can now also testify to the pleasures of Vietnam.

Simon Cox

To Be or Not

WHY RETAIN THE BSGDS?

Over the past few years we, in the British Society for General Dental Surgery, have become increasingly aware of falling numbers and 'natural wastage' affecting the future of our Society.

We have an ageing membership, many of whom are no longer in practice, lower attendances at our annual meetings and, in the opinion of many, we seem unable to decide what our future should be.

Some have already decided: they feel that we have achieved our function in helping to set up the Faculty of General Dental Practice and that we should now disband.

But there are others amongst us who recognise the unique character of the BSGDS and, with it, something that we ought to strive hard to save.

A few months ago a small group of members met under the Chairmanship of our present President, Chris James, to discuss the future of the BSGDS. The meeting produced more questions than answers, I'm afraid, but we decided then that we should draw up discussion documents to help members when we vote on any changes at the next AGM.

So, if I'm keen that our Society should continue, what should the future BSGDS look like?

I would suggest that we start our discussion with our strengths.

Without doubt our greatest strength is the quality of the members of our Society, which is evident in the quality of debate at the scientific meetings. How many times have we heard speakers comment that they have never talked to such a knowledgeable group before, both at the meeting and in the bar afterwards! Recently, the Committee has attempted to encourage more attendance from FGDP Members local to the Conference Venue. Speaking to these members after the meeting, I was surprised how many asked about the BSGDS. Surely this indicates a group of practitioners who would be interested in joining the BSGDS if a mechanism existed for this.

Then there is the strong sense of 'family' generated when we meet for residential conferences and for trips abroad. In essence we are a club. We may not meet for a year or two, but when we do it's as if we've not been apart and friendships between members and their wives, husbands and partners are picked up where they were left off at the last meeting.

Our weakness is that we have not been able to recruit sufficient numbers of new members since the MGDS Diploma was discontinued. We don't need large numbers to continue our Society, but we must have some, otherwise we will cease to exist in a few years.

Our Membership Fee compares well with other specialist societies, but we are still lagging behind them when it comes to a Newsletter and an active website. On the other hand, our one Conference per year compares well with the other Societies, and the foreign conferences are 'second to none'!

So what would my suggestions be?

- Open the Membership to any dentist with a post-graduate diploma or degree, provided he or she is proposed by two existing members
- Actively assist the unhappy individual who has to edit the Newsletter with articles and photos –
- Use the website, inserting practice details and updating as required

Changes to the constitution were made in 2009 to include holders of MSc's and FFGDP to be included in our membership. We need, as well though, to be active in identifying 'suitable' persons and 'talk the talk' about our terrific Society. We could use pointers by handing out a 'spare' magazine and suggest they visit the website. If interest is re-generated and new members start to join, then we can pursue the idea of a College of Dentistry, a subject dear to many of our members' hearts, and an aim of the Society. With the past close involvement of our membership in the FGDP at the Royal College of Surgeons, I am sure we can be a force for good in this matter.

I believe that there is still a place in dentistry for a small, select generalist Society. Perhaps a slightly less select, invitation-only group, will ensure the future of the BSGDS and may provide a platform for an improvement in dental post-graduate education and increased quality of care for our patients.

Trevor Bigg

THE FUTURE OF THE BSGDS – its Revitalization Programme

In 1925, T.S. Elliot wrote "The Hollow Men". Its closing lines are: "This is how the world ends... not with a bang, but with a whimper". Sadly this seems to be direction the BSGDS is moving in. I, for one, feel passionately that our society should survive. I have been proud to be both a member and President, but I am sure it is plain to all we cannot continue with a declining membership and no clear forward direction. I have had a conversation with Peter Briggs, a keen supporter of our society over the years, and also known for his clear no-nonsense approach. He was both shocked and saddened, that we have come to this, but, perhaps not surprised. Our members are ageing, many are retired or close to retirement and have heavy commitments which eat up time. There are few members with the energy to shake our society down and get it moving once more.

A group comprising past presidents and committee met in January and several suggestions were made. Perhaps the society should be wound up or simply merge into the Faculty? Both ideas drew some support, but, if either of these happens, I feel we will be swallowed up and disappear forever. The Faculty seems to have become more focused on producing diplomas than promoting excellence in Dentistry: they are **not** the same thing. There was also talk of forming a College of General Dental Practice, an idea which has a great deal of merit, but again, who will commit the time and enthusiasm to making this work? If it is in collaboration with the FGDP, then surely, they would take the credit! We need to recognize that real effort needs to be made by dedicated people if the society is going to continue.

In the past (and maybe still) we have been considered elitist and exclusive. We have something special and we should be inviting our respected colleagues, technicians and PCDs to share with us. At the moment, unless one is on the 'approved list', one is not welcome! In an age where exclusion is frowned upon, we do need to encourage the attendance of all members of the team. In attempts to demonstrate the friendly nature of the society and its existence, local practitioners and VDP's have been encouraged to attend more recent annual meetings and this has led to very favourable comments from non-members. We need to capitalize and further that approach to increase membership and move the average age away from retirement! We need to remember that professionals and staff have a choice and we should not confine our meetings to just dentists any longer. Perhaps a new grade of associate member could be extended to all, with full members retaining voting rights.

A society that has re-invented itself is the British Society of Prosthodontics. I do not advocate we either mimic or join them although I am told we would be most welcome! I would encourage people to visit their website: **http://www.bsspd.org/**: they have facebook and twitter pages and have great variety of approaches from a CPD 'roadshow' to 'webinars'. By comparison we have not focused on our website and, indeed, when it was updated 3 years ago, I understand there was a general feel that the financing should be restricted. We need to engage modern media interaction, again, with enthusiasm, if we wish to be attractive and be seen to have relevance. So, what is our future? We have a huge amount of experience and contacts and we have many friends overseas; we are a well respected group. We can easily take the BSGDS on the road, giving seminars in the UK and abroad to undergraduates and qualified dentists. We should explore the possibility of being a focus group to influence Government or Faculty policy. If we want to be taken seriously, we need to be proactive. Finally we must get new members of good standing by nomination, perhaps via a proposer and seconder and be more inclusive. The alternative option is a slow protracted demise with the BSGDS becoming a sort of 'members only' dining club until the last of our "Hollow Men" whimpers away.

Steve Perry

To Be – that is the Question

THE CONSTANT DILEMMA

The one constant item in our BSGDS AGM every year is the future of the Society. Every year we agonise over facts over which we have no control.

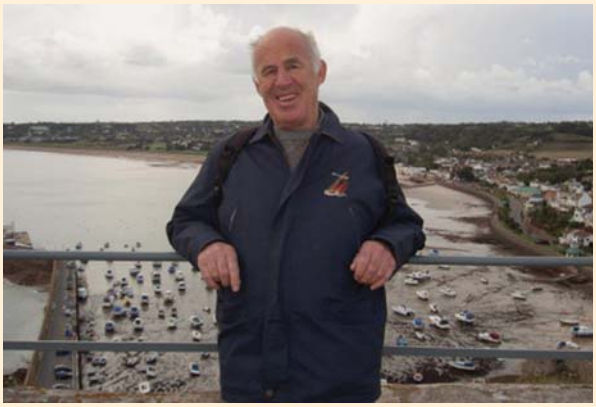
Firstly there is the restructuring of the Faculty's examinations along with the rapprochement of the FDS and the FGDP Boards. Whatever the advantages/disadvantages of these reforms it has inevitably cut off our membership base. Secondly there is the competition from the specialist societies. They might not do things better or with so much élan but many of them do it more comprehensively. More importantly, all the other societies give weight to a career structure.

Our founder members aim and objective was to find an academic home for general practitioners. Notwithstanding the early skirmishes between the Conference of Vocational Training course organisers and the FDS RCS Committee of General Practice this was achieved almost wholly by our current and retired members. We should be intensely proud of this achievement. What the Society set out to do has been done. However, we cannot hide from the fact that the demographic of postgraduate diplomas has changed. By all means some of us can go on meeting as an old boys and girls dining club but our posturing of making a unique (some would say a conceited) contribution to primary care should go. In Torquay we should support an orderly and constitutional winding up of our affairs and the incorporation of the Society's expertise and resources into the Faculty.

Many will be saddened by the loss of social cohesion of our group, particularly our partners. They will miss our meetings. A complete stranger watching us greeting each other in the hotel lobby for the first night drinks reception would surely marvel. It really is a question of shared values and those labelling us elitist are probably right. But this is irrelevant. Why? Because our contribution has already been made.

We should leave it to our executive to decide how the BSGDS name should be remembered. It need not become a footnote in the Faculty's history. We can wind up our affairs with dignity.

Edgar Gordon



KEEPING THE BSGDS ALIVE – what does this mean in practice?

If we decide to continue with the BSGDS at the AGM in October 2012, what will this mean in practical terms? There has been a general consensus that we should support the founding of a College of Dentistry but it is unclear how we would go about this. Should we be raising money, writing letters to the dental press, canvassing the politicians? What do we actually need to do?

If we simply carry on as we have been doing then the following assumptions can be made:

- Membership of the BSGDS will continue to decline.
- There will be little of interest at our Conference to attract back those members who have followed a Specialist career pathway and who are now more inclined to go to their own Specialist Conferences.
- Revenue from membership will decline.
- The average age of members will increase (making it even harder to attract young members).
- The proportion of retired members to working members will increase (with a knock-on effect of fewer people attending the lecture part of the Conference).
- It will become harder to attract sponsorship for the Conference, Magazine and Prize as the Society will be seen to have lost its USP (unique selling point).
- We won't have sufficient revenue to fund a research Prize in the same way as we have done in the past.
- The Society will continue to be seen as 'elitist' by some dentists who are eligible to join but choose not to.
- We will still struggle to find people willing to take up a place on the BSGDS Committee even though we only 'meet' 2-3 times a year (normally by tele-conference for 1 hour). If we are going to become more proactive, will it be easier or harder to find volunteers?
- Dentists are busier than ever, mainly due to the increased burden of bureaucratic red tape. Much of this extra work is completed at home in the evenings and weekends.
- The vast majority of the BSGDS membership has little or no contact with the Society from one year to the next (apart from an annual magazine, communication about subs/conference and access to the public part of the BSGDS website).
- Times have changed… Compared to the early 80s, there is now a wealth of good postgraduate courses available in the UK. Dentistry has become less of a profession and more a business. Social networking is the main way in which the Generation Y, also known as the Millennial Generation, communicate; even email is seen as outdated.

Insanity has been defined as repeating the same behavior and expecting a different result. I think we would be mad to carry on unless we radically change. I don't think there is the will or the manpower within the membership to make sweeping changes. Most of all, I don't think there is a practical action plan outlining exactly what the changes should be.

Paul Downes

Please let us know you thoughts.
– chrisjthedentist@hotmail.co.uk
– www.bsgds.com

2011 Annual Conference

Phil Lang organised a superb conference near Newbury in October 2011.

It was refreshing to return to 'coal face' dentistry. We re-visited the 'Onging Role of RPDs' with Charlotte Stilwell being reminded that not everyone has the means or the inclination to replace removable prostheses with implants. We thought again about the fundamentals of retention and stability and were reminded about major connectors other than traditional skeleton frames or bars.

In the afternoon Ailbhe McDonald of the Eastman addressed 'Tooth Restorability' and gave evidence for the continuing role of amalgam and cast gold restorations. She supported her presentation with statistics to ensure we were made aware that an 'all ceramic' approach is still not a tried and tested clinical modality.

Both lectures are available on the website together with clinical cases to test your skills – *see below for reminder on access.*

We were treated to excellent light entertainment after dinner: a Barber Shop presentation with a difference – a very 'risqué' female conductor – and she, and they, brought the house down! I am not a fan of 'Barber Shop' but I enjoyed their presentation very much indeed. It was made all the more special as Phil Lang was a member and indeed, despite being unwell, he was able to participate that evening. The Dean of FGDP, Russ Ladwa, gave the after dinner speech in which he alluded to a future role of BSGDS being proactive in the formation of a College of Dentistry.

Trevor Bigg was deemed worthy of receiving the Straumann Award, but I could hardly keep a straight face when he mumbling to me just before, 'Wouldn't it be funny if it came my way!' Not withstanding his comment, he is indeed a worthy person to receive this honour!

A truly memorable day and evening.

Auriel Gibson

Immediate past president, the late Dr Philip Lang with Dean of FGDP, Russ Ladwa and new president, Chris James.

How to access the *'members only'* section of the BSGDS website.

www.bsgds.com

You need to Login at the bottom of the Home Page to be able to see these pages as they are not accessible to the general public.

If you have forgotten your username or password, just follow the instructions on the Login page. All these details are managed by MoonFruit, the company who host our website.

Full Arch Rehabilitation Case using the ASTRA TECH DENTAL CRESCO™ System

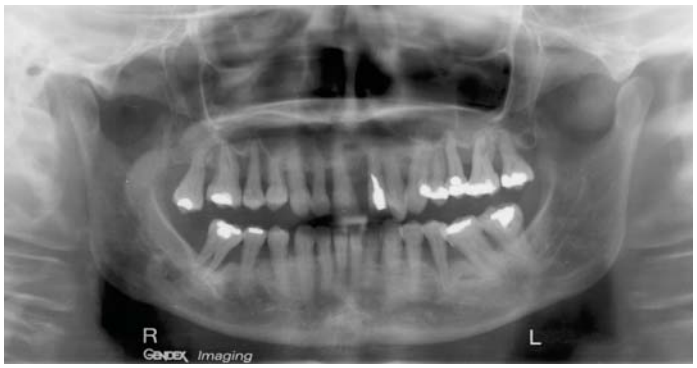
We are all occasionally faced with patients who have teeth of hopeless prognosis and for whom the clearance of at least one arch is the only option. The prospect of wearing a removable denture becomes unbearable for these patients and they are often adamant that they will only tolerate a fixed prosthesis that "does not move" in their mouths. This leads us to the option of dental implants and a fixed bridge, arguably one of the most challenging treatment modalities for the implant surgeon and prosthodontist. A case is illustrated to show a successful outcome using a technique that was thought to be state of the art a mere five years ago but which has become superseded already by the inexorable advances in implant dentistry. The author then reflects on his views regarding the contemporary advances in this field and how they may affect the UK dental market today.

The option of a screw-retained bridge has several advantages over that of a cemented one, but demands more precision in the surgical implant placement and prosthetic reconstruction. Specifically, the implants should ideally be placed axially and spread evenly to support the loading of this type of bridgework. The prosthetic supra-structure necessitates a passive fit on the implants and the occlusion and final appearance should be acceptable to both the dentist and patient. One way to help overcome these problems is the CRESCO™ Precision Method. Pioneered by the Astra Tech Dental implant company, it is also available for almost all the premium brand implant systems on the market today. The key to achieving a passive connection between the supra-structure and the implant in a direct connection is to cut the initially cast bridge support horizontally and then to laser-weld the pieces together once the position has been corrected to the ideal passive position.

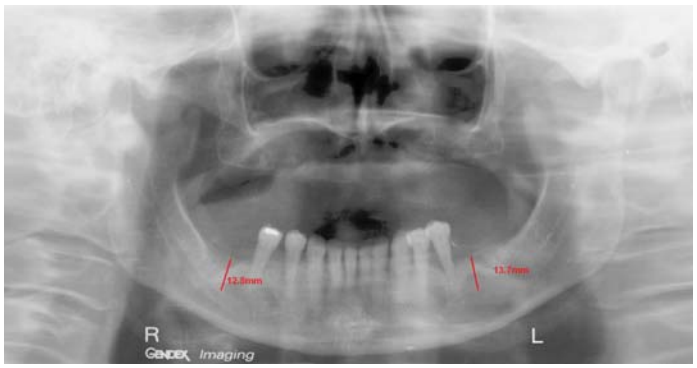
Case Study

The following case describes the situation in a 50-year-old professional lady for whom the prospect of wearing a full denture was not an attractive long-term option. Following an initial assessment, the upper arch – which had a BPE of 4 and * – warranted a referral to a Specialist Periodontist, who concluded that the upper teeth needed to be cleared and the lower teeth preserved as a shortened dental arch. The lady was referred to me for the reconstruction and the initial fabrication of an immediate denture. This was fitted following the surgical removal of the upper teeth with a periotome so that I could preserve of as much of the potentially useful alveolar bone as possible.

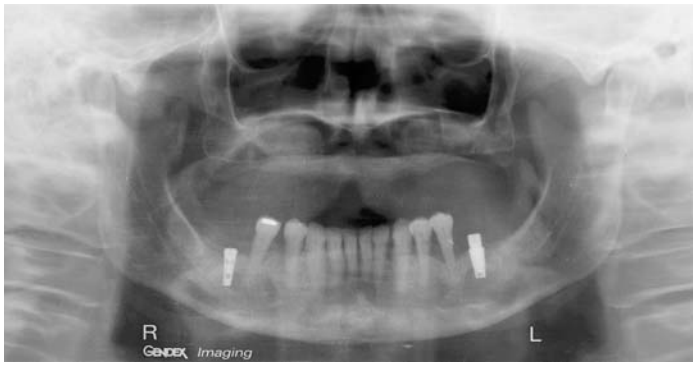
Following a period of 3 months of immediate denture wearing in the upper arch, I carried out simultaneous,



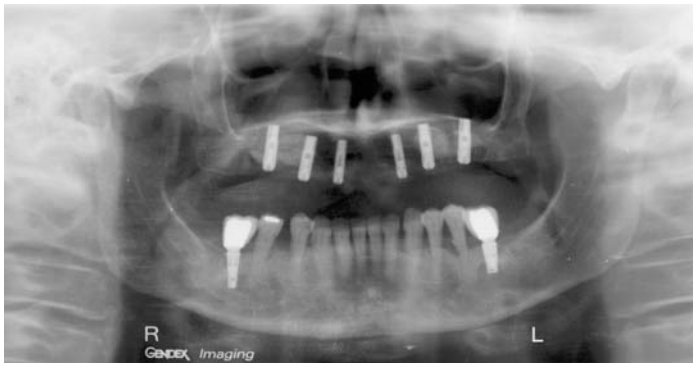
Pre-op



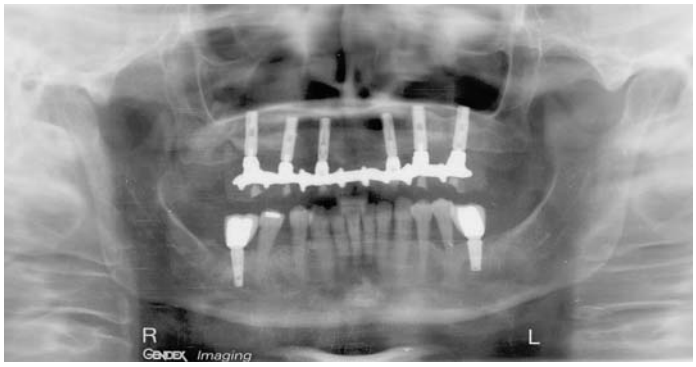
Post xlas



Post sinus graft and lower implants



Implants upper arch



Cresco bridge in situ

bilateral sinus grafts under local anaesthesia to increase the bone height for implant placement in the upper premolar to molar sites. BioOss™ allogenic bone and BioGide™ collagen membrane was used in a bilateral window technique to raise the sinus floors and the sites left for a further 4 months to allow healing and consolidation. I then placed six Astra Tech dental implants symmetrically across the arch using a surgical stent to eventually support the definitive CRESCO™ bridge. A transitional denture was made and periodically relined to make it comfortable for the lady over this period of time.

Second stage surgery was carried out six months later to expose the implants. A special tray was used with the CRESCO API™ (All Parts Included) kit and the new metalwork try-in was checked in the mouth. The choice of materials for this stage includes titanium and CoCr, the latter having been chosen for this case, with composite teeth. Cobalt chrome is relatively easy to cast accurately and the composite teeth gave strength, durability and reduced the weight significantly compared to porcelain (which does not bond predictably to cobalt chrome or titanium anyway).

Finally, the CRESCO™ bridge was screwed into position and the cover holes protected with cotton wool and glass ion omer cement. The bridge has been in place for over 60 months now, the lady is very happy and no problems associated with it have been reported although there is now wear on the composite teeth themselves, which can be readily resurfaced in a single visit.

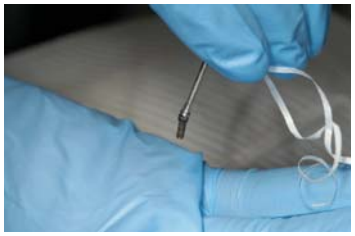
Care and maintenance

These and other implant patients are seen on a mandatory 3-monthly Hygienist recall basis. Annual one-yearly follow-up visits are also arranged to check for wear on the suprastructure, loosening of components and any signs or symptoms of associated pathology. The Hygienist is particularly astute and has been trained to alert me to any pathology or adverse signs and informs me immediately so that I may intervene at the earliest opportunity. The Specialist Periodontist also reviews these patients annually to monitor their periodontal condition and ensure that this remains in a stable and quiescent phase.

Final thoughts

As good as the advances in full arch reconstructive dentistry with implants appear, the long term results need to be carefully monitored and reported on. The Astra Tech Dental CRESCO™ system was regarded as one of the most innovative and best systems available for the provision of a screw-retained, implant bridge. However, I now incorporate the advances in CAD CAM (computer aided design, computer aided manufacture) technology by using milled titanium frameworks (CAM StructSURE®) as an alternative technique, which offer significant advantages in tolerances of component fit and strength. It should be clear from the time frame and attenuated, pictorial representation of this case, that whatever the supra-structure, this is a long and involved process, typically taking 12-18 months to complete from the start of the case.

The historical evolution of implant supra-structures leading to full arch reconstructions is truly fascinating and has evolved greatly, especially in the last ten years and we should take note. Two distinct modalities are now prevalent; the first one, of which the CRESCO system is an example, requires the careful preservation of residual

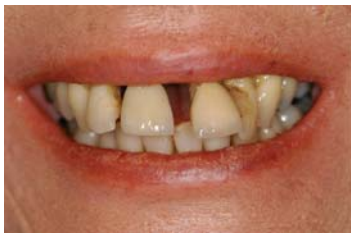


Corsodyl gel technique to carry screws – view 1

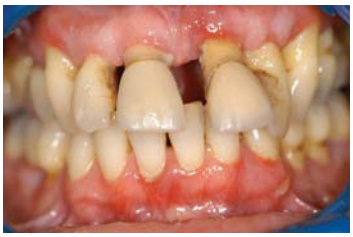
Corsodyl gel technique to carry screws – view 2

Corsodyl gel technique to carry screws – view 3

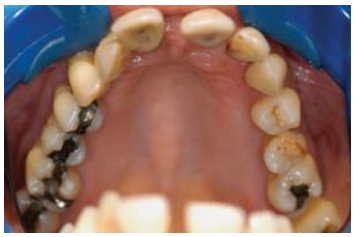
Corsodyl gel technique to carry screws – view 4



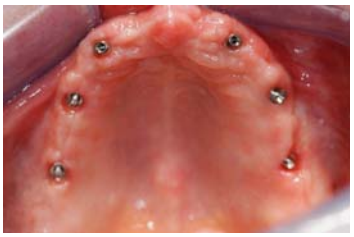
Pre-op smile view



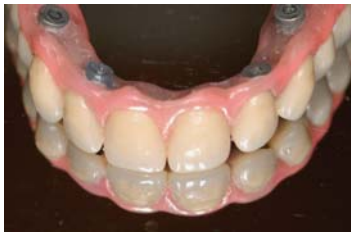
Retracted ICP



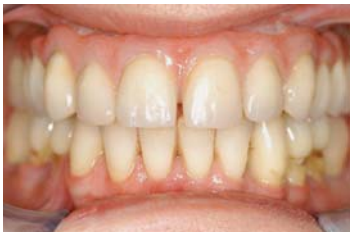
Pre-op upper arch view



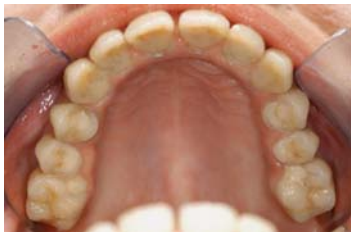
Post-implant placement view



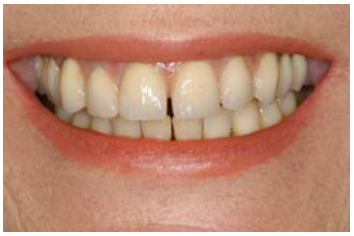
Completed upper CRESCO bridgework



Post-op retracted view



Post-op upper arch view



Post-op smile view

bone and augmentation of the same to allow implants to become fully integrated prior to the placement of the fixtures. Then after an appropriate period of healing and osseointegration, the construction and loading of the implant suprastructure can take place. The other modality involves the *immediate loading* concept, which I would argue will become exponentially popular in the imminent future, for obvious reasons of time saving. However, this is not surgery for the inexperienced and this is an important point to always remember.

Since the early, relatively crude option of the Novum™/ "Teeth in a Day" system pioneered by Nobel Biocare in the early 2000s we have come a long way to very refined techniques for full arch reconstruction of failing dentitions. These concepts have developed from the compelling literature on acceptance of predictable placement of angulated implants and the realization that axial loading of implants is not mandatory. In addition, the specific design of implant profiles and thread design to enable excellent primary fixation (and the crucial immobility to less than 150 micrometers of micromotion and a gain of at least 40NCm of torque), has meant that immediate loading of a full arch can be achieved to such an extent that the patient can physically bite through an apple immediately after the fit of the provisional arch! These systems are already well established globally but are coming to the fore in the UK market, especially as they are becoming patient driven with the availability of information so readily. It is clear that in London's West End and many forward thinking implant practices around the UK (and now at least one of the leading dental corporates) are offering the kind of rehabilitation service pioneered by Paulo Malo in Portugal. The ones that will make the greatest impact on the current UK market in my view are the Nobel All-On-Four™ system, the Ankylos Syncone™ system, and the Biomet 3i Columbus bridge system. A place still exists for the CRESCO system and CAD CAM milled titanium frameworks for those patients not suitable for this immediate loading technique, and we should keep abreast of the evolution of knowledge with a clear mind to the evidence base for our decisions.

Anil Shrestha
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Registered Specialist in Prosthodontics
Clinical Director, Lister House ICED
(*formerly the practice of Dr Michael Wise*)

References available on request.
Referrals gratefully accepted at Lister House ICED.

Lake Victoria Disability

Lake Victoria Disability Centre Workshops in mid town Musoma.

Staff learning CPR from Dr Jo Omar and the new ICU unit at the regional hospital in Musoma, Feb 2012.

What a welcome! What an exciting scene met our eyes when we arrived at the 10th anniversary of the Lake Victoria Disability Centre (LVDC) in Musoma, Tanzania on 21st February 2012. Upwards of 200 people were gathered on the new four acre site to participate in the unveiling of the foundation stone of the new centre. We were wonderfully welcomed in true African style by the most impressive singing and dancing. Both the Mayor of Musoma and the Regional Development Officer spoke highly of the LVDC, praising the work and care that was being offered to the disadvantaged in a country that still despises disability. The Asian Odontological Group (AOG) has contributed considerable funds to the dental unit in Musoma and Manny Vasant and Pommi Datta both spoke representing the AOG contingent of eleven from the UK who were privileged to be part of this momentous occasion.

Dennis Maina, a gentle African man, first had the vision for helping those less fortunate than himself in Musoma. He quietly started a charity on the lake-side 10 years ago teaching deaf and dumb children to communicate. It is thought that approximately 10% of the population is disabled in one form or another: polio and measles still cause paralysis and deafness. He soon realised that there were significant numbers of young men who were unable to walk because of polio as infants. Being an engineer by background, he set up a workshop in the centre of town to teach young men welding skills to make their own hand pedalled tricycles and these have dramatically changed the lives of these young men. Gradually other workshops have been added; a screen printing business, a sewing machine class and a thriving shop are all now present in the town centre. This significant presence in the centre of town is helping to break down the negativism towards disability that exists within the community.

The Lake Victoria Disability Centre is also working closely with Graham McClure from the C of E diocese. Graham, a builder from Blackheath, London, spends six weeks at a time in Musoma heading up a building project of individualised water tanks to collect and store rain water. This system is 'enabled' by members of the community

The water storage tanks and the people for whom they are being built by Graham McClure in and around Musoma.

Centre's 10th Birthday Party

earning 'points' when Graham and his team move in and construct his or her own concrete tank. Graham's building skills have been invaluable in assisting the LVDC in their new building project at the new site on the outskirts of the town.

So… where does the dentistry come in? In 2008 a small group of dentists visited Musoma and carried out some basic dentistry within the local hospital. Part of that trip was to assess the feasibility of improving the dental facility within the hospital and part was to assess the dental and oral disease need. It became apparent that the enhancement of the dental unit within the hospital was not appropriate since it could not be adequately maintained and managed as the personnel were forever changing and there was lack of 'ownership'. By working closely with the Lake Victoria Disability Centre, however, the means to placing a dental unit that could be maintained and looked after has become a much more feasible proposition. It was exciting therefore to see the foundation stone being unveiled on the outside of the 'AOG Building' that is to house this new dental surgery.

Currently the dental need is low. Musoma is, however, rapidly changing. It was apparent at this visit how much more mobile the population had become: many more cars, bicycles and scooters were in evidence. The power supplies are less erratic and Fanta and Coke seem to be universal! As the standard of living 'improves', there will obviously be an increasing dental need. In addition, the population statistics are frightening! According to a local worker there is a population explosion with currently 25% under the age of 5 yrs and 40% under the age of 15 yrs! (This is partly as a result of the previous generation being badly decimated by AIDS and the children of this generation surviving better).

The AOG, and the LVDC in Musoma are working closely together to develop the service to this needy area so that care can be delivered locally. Another dental/building trip is being planned for 7th-21st July 2012 and anyone interested in joining this trip either in the dental capacity or the building capacity should contact Graham McClure (graham@gomad.org.uk) or Manny Vasant (mvasant@btinternet.com).

Auriel Gibson

Laying the foundation stone of AOG House in Musoma at 10th Anniversary of Lake Victoria Disability Centre.

Tree Planting for posterity by Manny and Meena Vasant, Dennis Maina and the Mayor of Musoma.

AOG, BSGDS Kenya, Tanzania, South Africa Trip

February 2012

AOG Group Kenya February 2012 – weary but well-fed ☺

This intrepid group of chewing preservers didn't set out to deliberately chew their way through south east Africa but, as things turned out, they made a reasonably good job of checking out the chewables in this amazing part of the world.

Joseph at the front door of the Safari Park Hotel with the logo of the Chaine des Rotisseurs – the guild of goose roasters!!

No sooner than they had touched down in Nairobi, they transferred to the Safari Park Hotel, an establishment long affiliated with the Confrerie de la Chaine des Rotisseurs, the worldwide gastronomic club and the universal guild of goose roasters. True to the mission statement of the Chaine, the Safari Park boasts one of the two grand barbecues in this sprawling metropolis. It goes by the name of Nyama Choma Ranch, *nyama choma* meaning marinated, spicy barbecued chunks of meat!!

Pankaj Patel had warned us that this would be death by char-grilled flesh. Enough camel, goat, beef, boar, ostrich and crocodile to feed a Roman legion, but the British contingent was not to be outdone and not one of us had waved the white flag by show-time. Good as this show was, many couldn't wait till it was over to complete their collection of exotic tastes. For the more guilty of conscience there was dancing deep into the night.

Barbecue at Nyama Choma Ranch in the Safari Park Hotel – a spit the size of a practice.

Auriel and Arrif working it off!

And so things went on, pretty much the way they'd started. In the space of a few days we moved from Nairobi to Lake Naivasha – the Country Club is a relic from colonial times, with a bar atmosphere and cuisine to match. On the final night head chef Andrew laid out a torch-lit barbecue for our party complete with Masai warriors for entertainment, another veritable feast in true Kenyan style - pity the wine was not Kenyan too!

Ladies at table at Lake Naivasha Country Club.

Every day began with another feast – far and far away from your daily fast-breaker – which left everyone wondering how they could possibly face lunch. Experiencing such local delicacies as *mandazi, uji, matoke* and *ugali* washed down with pots of *chai* even at those unearthly hours was unforgettable – gone is the two-minute coffee and toast, in comes the multi-course daybreak meal – The human body is a marvel at adaptation! One fine day, having set off after another early feast into Lake Nakuru National Park there was not a soul in the party who didn't partake heartily of lunch at the Sarova Lion Hill Game Lodge, a

lavish spread if we hadn't already seen several, in a stunning setting, and then digging in at dinner time yet again. No wonder there were several nodding heads at the post-dinner discussion!

Bubbly breakfast for the brave balloonists.

For a trailblazing few, the glorious hot-air balloon flight over the awakening Masai Mara was just a preamble to an even more glorious breakfast, champers and all, cooked in the savannah and served by red-liveried staff.

Watch this lot eat!!

The short hop from Keekorok Lodge to Musoma didn't bring much respite. At the celebratory dinner in the Africa Lux Hotel, the local Council laid on a comparatively modest but certainly elaborate buffet that contributed to a good night's sleep as much as the sheer exhaustion from the previous several hours.

The final chapter in this saga took place in Cape Town: even more elaborate breakfasts at the Westin Hotel, Indian restaurants galore, the Food Court at the Casino… and the seafood!!!!!! Great wine tasting at Fairview Estate with such exotic wines as Goat Rotie and the Goatfather (!) accompanied, naturally, by plenty of goat's cheese (!!!) and then, a couple of notches up, Spier Winery with its flagship Frans K Smith, a mind-blowing wine they are justly very proud of.

Glorious seafood ☺

At the Casino – gambling is for mugs!!

Gala Dinner @ The Wild Fig – Cape Town

But lest we forget what this trip was all about in the first place, the trip to Musoma to lay the foundation stone of the New Lake Victoria Disability Centre as well as the joint KDA/AOG Conference in Nairobi and the Smile-On Clinical Innovations Conference in Cape Town made all the above relatively superfluous, though none the less enjoyable and left everyone yearning for more – Manny and Pommi, please note!

Jo Xuerebj

Manny… Caje… Pommi and Pankaj at the KDA/AOG Conference.

Pommi presenting AOG House plaque.

Wine and Cheese tasting at Fairview and Spier wineries in Stellenbosch, S Africa – tearing Pommi and Ghite from their beloved Tusker mugs didn't prove too difficult after all.

News from Faculty

Dr Trevor Ferguson was elected to be the 8th Dean of the Faculty of General Dental Practice (UK) on 2nd March 2012. Trevor will take over from the current Dean Russ Ladwa in June. The Faculty Dean is elected to serve for up to 3 years, providing clinical leadership and promoting the Faculty's strategy and policies in the professional and public arenas.

Trevor Ferguson is a General Dental Practitioner who has been practising in North Wales for the past 25 years. He has previous experience of vocational training, tutoring on postgraduate courses, University teaching and maintains a continuing active commitment to primary care dentistry. Dr Ferguson was a founder member of the FGDP (UK) and has been a member of the Faculty's Board since 1998.

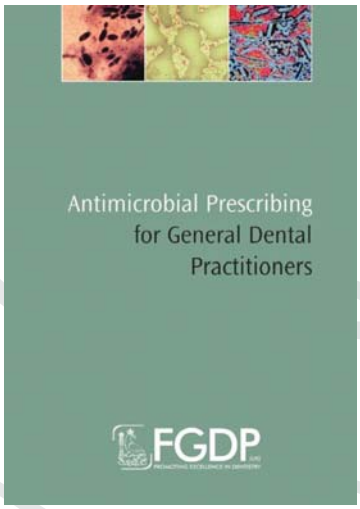
Upon being elected Trevor Ferguson said:

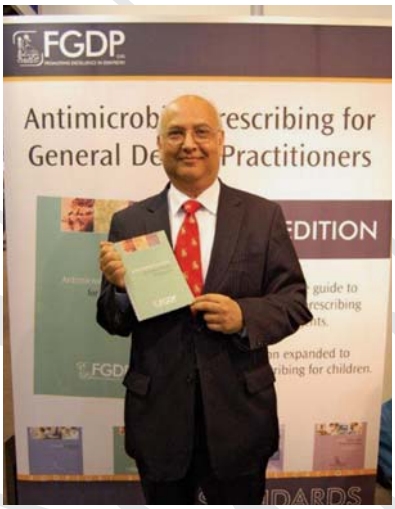
> *"The achievements of the Faculty to date have been remarkable, however we live and practise in very challenging times. The future success of the Faculty is dependent on increasing membership, strengthening our position as the standard setting organisation for general dental practice, as a provider of postgraduate education and training, and also ensuring a greater voice in the future of patient care. The next few years are crucial and require significant vision and enthusiasm to achieve these goals. I am delighted to have been elected to the position of Dean and I look forward to working towards these goals, and articulating the Faculty's position within the Profession."*

Current Dean of the FGDP (UK) Russ Ladwa congratulated Dr Ferguson on his election saying:

> *"Trevor Ferguson has contributed hugely to the FGDP (UK) to date. He has all the right qualities to lead the Faculty forward at a challenging and critical time for our profession. I wish him well!"*

Also elected on the 2nd March were two Vice-Deans, with Lawrence Mudford being elected for a second successive term and Naresh Sharma for the first time.





Dean of Faculty, Rus Ladwa, at launch of New AntiMicrobial Prescribing Standards

Dr Trevor Ferguson Dean of Faculty

An inspector calls

Experiences of a CQC Inspection!

It all started on Thursday the 9th of February, when I returned home and with drink in hand, idly sat in front of my computer looking at the day's emails.

One had arrived at 16.21 and was titled 'CQC Inspection of Dental Practices'. I don't know about your Inbox, but I've been inundated with emails from the BDA, DBG, Denplan and many other companies offering support and advice in case we have a CQC Inspection. I thought this email was from yet another company, but opened it before placing it in my CQC Folder to read or ignore later.

That was when I saw that the first sentence read:

"Dr Bigg, your practice is on my list for an inspection."

What!

I read it again:

"Dr Bigg, your practice is on my list for an inspection. I would like to do a site visit on Tuesday 14th February. I have previously attended over the lunch period as most clinics close for lunch. Most of the inspection can be done with your practice manager and I would only need 10 to 15 minutes with you… The inspection should take no longer than two hours."

I must say I was in a state of shock after reading this.

Whenever I've been with other dentists and the subject of CQC Inspections has come up, I have, rather smugly, asserted that it will be a year or more before the Inspectors get round to visiting our practices. Didn't the newspapers say that there have been 70% fewer inspections of care homes since dental practices have been included in the CQC's remit? Surely, they've been stepping up care home inspections to remedy this?

But no, here was my appointment and my first thought was, can I put it off?

So, quickly on to the CQC website to see how much notice they needed to give for an inspection.

48 hours and, in fact, they are entitled to unannounced visits, so I was lucky that I had the weekend before they came, giving me two extra days.

Next, on to the BDA website, click on Dentists, and type *'BDA CQC support kit'* in the search box. The BDA, bless them, have enabled any dentist, even non-members, to download information about CQC Compliance. But when you open the page it takes a while to get your head around the vocabulary and when you see the list of 16 Outcomes to be covered, it's easy to become defeatist.

However, remembering the old saying "How do you eat an elephant? One bite at a time!" I go back to the email and note with relief that there are *only* 4 Outcomes to be inspected, relating to the care and welfare of our patients, *viz:*

Outcome one: Respecting and involving people who use the service

Outcome four: Care and welfare of people who use the service

Outcome seven: Safeguarding people who use the service and

Outcome eight: Cleanliness and infection control

Now the BDA Support Kit is very comprehensive. But I needed something simpler to follow, so I turned to the Denplan publications and came across the Denplan Care Quality Commission Guidance "An Inspector Calls".

This is very well laid out and includes introductory notes (for the dentist's information only), a cover page, a "Statutory and Additional Information" page with 'tick boxes' and individual pages for each Outcome. These pages are divided into Requirements, Examples and, most useful of all, Evidence with a list of documents to be included in this Outcome.

I was then able to work my way through the lists, referring back to the BDA Support Kit for the more 'esoteric' policies ending up at a quarter past midnight on Monday, with a ring file and all the necessary documents placed in the order detailed by the Outcomes.

Next day the Inspector calls. He seemed a very pleasant fellow, smartly dressed but a little distant, even refusing two offers of tea or coffee. I have a tiny practice, small but perfectly formed, and so we first invited the Inspector into my surgery. I treated him as if he was attending one of the practice visits I have had over the years for the MGDS and Fellowships and, unbidden by him, we showed him our cross-infection protocols, zoning and instruments stored in lidded trays and sealed see-through pouches. By the time we'd finished he seemed a little dazed by the quantity of information I had provided him and returned to the Waiting Room to work his way through the ring file.

I started to treat patients again, and was somewhat surprised that each patient was interviewed after their appointments. We even had to call one back just before she left the building! The questions asked were mainly about their past experience of the practice and whether they knew how to complain. One lovely lady said "I've been seeing Dr Bigg for 40 years and haven't needed to complain yet. If I want to know how to complain I'll ask"!

Finally the Inspector went through a list of questions he had prepared the previous day. Having had Denplan Excel Inspections, which are very thorough and have pages of boxes to tick, as far as I could tell the Inspector has no guidance from the CQC whatever and makes up his own list. True to a warning I'd had from a friend, I was asked how the practice respected the rights of vulnerable adults, but otherwise the questions were searching but not too difficult.

Then, with a smile and a "You are compliant", he was gone.

So what did I think of my first Inspection?

I'm afraid to say, for all my cursing over the past months since Inspections were announced I found it very useful. And the Review of Compliance was so positive that I'm going to have it added to my website! Who would have thought that a CQC Inspection could be an aid to advertising the Practice?

Finally, for those Private Practitioners who've never sat a Diploma that includes a Practice Visit, this will be the first time anyone has taken a proactive step to ensure that the care and welfare of our patients is protected and, surely, that can't be a bad thing!

Trevor Bigg

It is now generally perceived that the registration of dental practices has been a' botched job'. The Government report on the workings of the CQC has criticised its Chief Executive, Cynthia Bower, and been partly responsible for her resignation. Part of the responsibility for her resignation, however, really remains with Government since it failed to provide sufficient numbers of knowledgeable human resources to deal with the special nature of dental practice. As a result the number of care home visits dropped by 70% resulting in a public outcry as there is a history of mistreatment of our elderly population.

Listening to those who have already had a CQC inspection, has also led to derision amongst dentists. For instance one perky practitioner, when asked if she ran the water line in the morning, replied, 'Yes, of course'. When asked if she logged the action of running it for 15 secs between patients, replied, 'Have you ever run or even observed the running of a busy practice? My nurse already has enough to do in cleaning and making ready for the next patient without logging a 15 sec water spray every time. We just do it!' Monitoring gone mad, I think! Thankfully the powers that be have now seen the light of day and CQC has been told to train its inspectors in dental matters. At last, hopefully, we will be treated with the respect that we deserve as the professionals we are without being treated as delinquent children who need to enter lines in detention. No wonder the GPs have given a reprieve in the registration process as their registration would have sunk the system completely.

It is appropriate, however, that we inform patients thoroughly about their treatment, the expected outcomes, the risks and benefits and options. By doing so, patients can give informed consent.

Arduous? Yes, could be, but with a little imagination, the arduous nature of this process can be reduced. Voice recognition systems are now very sophisticated and word processing has speeded up the process of inserting pre-dictated paragraphs. The after consultation letter to patients has become longer but by developing the role of a treatment coordinator, capable of discussing treatment in detail, expensive dentist's time can be delegated. My treatment coordinator rings the patient a few days after he/she has received the letter and asks if everything is clear and offers to answer questions and the options can be gone over again and discussed. In that way the enclosed consent is thoroughly understood and consent is then valid. The side-effects of this approach are considerable: rarely are treatments refused and patients feel supported and… there is free advertising – patients feel cared for and looked after and bang the jungle drum! Patients in my practice love Ann, my treatment co-ordinator and ask after her with disappointment if she isn't present when they arrive for treatment! There is a silver lining to every cloud! CQC? Parts of it are OK, if you think positive!

TEAM WORK

Moving Forward Together

'If everyone is moving forward together, then success takes care of itself' Henry Ford.

We used to try and 'make' a team by selecting people of different types. This process was never easy in a 15 minute interview even if the candidate spent half a day in the practice observing the systems while we observed them. But we really need to **'nurture or develop'** a team-people who are multi-skilled, transparent, competent, dependable, and, capable of communication, with each other and with patients.

And the secret is respect and transparency from the leaders first.

The team should have a mission, a sense of purpose that is focused equally on the patients and the bottom line. 'Mission' implies a zeal-hence 'missionaries'. Passion and zeal have become rather dirty words implying 'not cool' etc but in austerity perhaps these characteristics need revisiting. Passion is energising and exciting and such emotions are uplifting for the patient and the staff. Certainly there are a lot of patients out there who do not feel cared for and patients easily discern a practice where they are truly looked after. These practices will have high fees as this approach does not come cheap but the practice questionnaire will still have 'trust of the dentist' at the top and 'fees' at the bottom end of its list. Our job: to invest in nurturing our teams so that the caring is tangible to the patients.

OBITUARY

Philip Lang

I have known Philip as a friend and professional colleague for many years and was so saddened to hear of his passing. He endured his disability with great fortitude and good humour. He was a very forward thinking practitioner and was an active member of several associations. He was one of the first candidates to attain the Membership in General Dental Surgery and was a founder member of the British Society for General Dental Surgery. He was also a keen member of the British Society for the Study of Cranio-Mandibular Disorders.

His many interests included fishing, gardening, Barbershop and diving. On one occasion I was fortunate enough to buddy with him on a dive in Malaysia where we were both attending a BSGDS conference. Last year, as president of that society and despite his failing health, he bravely undertook to organise a most successful conference in Newbury.

He was an early pioneer in the use of splints to rectify chronic pain in the head and neck region. He practised in the Oxford area and more recently he teamed up with chiropractor, Dr Jonathan Howat, and working together, they were able to bring about pain relief for their patients which went far beyond what each of them believed could have been achieved on their own.

He is survived by his wife, Rosemary, their children, Penny and Robert and four grandchildren. Our sincere condolences go out to them and he will be sadly missed.

Helen Jones

Apart from being a founder member and attending almost every BSGDS Conference and Overseas Trip, Phil took over as Treasurer of the BSGDS in 2007 and became an active member of the Committee. He worked very hard in trying to reconcile the two BSGDS bank accounts into one, with which he made considerable progress. Anyone who has tried to do this will appreciate how much of an achievement that was. Then after two productive years as treasurer, he became President Elect in 2009 but continued to be treasurer as well. Phil knew when he became President in October 2010 that he was seriously ill, but he was quite determined to take and make a success of the post, undertaking treatment at the same time. It ended with a very successful Conference in October 2011 for which he needed a blood transfusion immediately before the Conference weekend. Phil was a very quietly determined man and the Society owes him a debt of gratitude.

Phil Lang commemorated by Mike Jones

Phil and Rosemary, who is a musician and music teacher, had a common interest in music. As I learnt at the funeral, Philip founded a choral group at his school, set up the Oxford Harmony barber shop group some 30 odd years ago, and of course put together the BSGDS Barber Shop group together with Dan Earp, Simon Cox and Chris May. He was a quiet and gentle man with enormous energy and leadership qualities.

Philip was also a very keen fly fisher. He regularly fished for trout at his local water at Farmoor, and made annual trips to fish Chew and Blagdon. He made a trip to Scotland each year to fish for salmon, and about 8 years ago joined Roy Dixon, me and some friends to fish for salmon in British Columbia.

Philip was also a very keen and green-fingered gardener.

I think Philip and Rosemary joined all the BSGDS overseas trips, and missed very few, if any, Annual Conferences. Being the Immediate past President and having organised the last Conference makes his death that much more poignant.

I spoke with Philip every now and then during the past year, and must say that he bore his illness with remarkable fortitude. Although he was a bit tired at conference in 2011, he really didn't let it stop him doing anything and that was remarkable. He retired from practice completely less than a year before his death.

Phil Lang commemorated by John Gamon

What Matters to Patients when their Care is delegated to Dental Therapists

T.A. DYER, J. OWENS, and P.G. ROBINSON

Aim

To explore the experiences of adult patients, and parents of child patients, when their oral health care is delegated to dental therapists.

Method

Cross-sectional narrative study using semi-structured in-depth interviews of a purposive sample of patients (n = 15) and parents of child patients (n = 3) who have been treated by therapists.

Results

Overall, participants reported positive experiences of treatment provided by therapists. Two main themes emerged from the data. The first; perceptions of the **Nature of Dental Services** appeared related to the second; **Trust and Familiarity** in the dental team.

Perceptions of the **Nature of Dental Services** ranged from viewing dentistry as a public service, to that of a private service, consistent with a more consumerist stance. Within this theme, three dimensions were identified: *Rationale for skill-mix; Team hierarchy;* and *Importance of choice and cost.* Consumerist perspectives saw cost reduction, rather than increasing access, as the rationale for skill-mix. Such perspectives tended to focus on hierarchy and a rights-based approach; envisaging dentists as the head of the team, and emphasising their rights in choosing a clinician.

Trust and Familiarity towards the dental team appeared critical for the therapists to be acceptable. Two dimensions were important in developing trust: *Affective behaviour; Continuity of care.* Two further dimensions were identified in this theme: *Experience over qualification; Awareness of therapists.* Where trust and familiarity existed, participants emphasised the importance of their experiences of care over the qualifications of the providing clinician. Equally, trust in the dentist delegating care appeared to reassure participants, despite awareness of the role of therapists and their training being universally low.

Conclusion

Regardless of perspective, views and experiences of treatment provided by therapists were positive. However, trust and familiarity with the dental team appeared critical. Trust was apparently founded on dental teams' affective behaviour and communication skills and continuity of care. There are implications for skill-mix if corporate bodies increasingly provide dental care. Staff turnover can be high, which might compromise familiarity, continuity of care, and ultimately trust.

Tom Dyer

Improving Childrens' Oral Health Knowledge with a brief Dental Care Professional (DCP) delivered educational intervention

B. DAWETT[1], H. BLAKE[2], P. LEIGHTON[3], L. BRADY[1], and C. DEERY[4]
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[4]Oral Health and Development, University of Sheffield, Sheffield, United Kingdom.

Aims

Individual oral health education during clinical encounters has been shown to be largely ineffective. Community-delivered approaches to oral health education may be warranted and fitting with national public health directives. This study aimed to assess change in oral health care knowledge and oral health-related behaviours in children and parents following group oral health education delivered to children in the school setting.

Methods

One hundred and fifty children (aged 8-10 years) received a 60-minute classroom based interactive educational session delivered by a dental care professional. All children completed a questionnaire on oral health-related knowledge and self-reported oral health-related behaviours before, immediately after and 6 weeks following the intervention. Parents (n = 27) completed questionnaires self-reporting oral health-related behaviours before and 6 weeks following the intervention.

Results

Deficiencies were observed in children's dental knowledge, which significantly improved following intervention ($p < 0.001$), with improvement evident at immediate follow-up ($p < 0.001$) and maintained 6 weeks later ($p < 0.001$). Significantly more children used dental floss 6 weeks after the intervention compared with baseline ($p < 0.001$). No significant differences were detected in tooth brushing or dietary behaviours. There was a significant increase in the percentage of parents who reported using dental floss six weeks after the intervention compared to baseline ($p = 0.03$).

Conclusions

School-based preventative oral health education can generate short-term improvements in children's knowledge of oral health, and aspects of oral hygiene behaviour for children and their parents.

Buphinder Dawett

Acknowledgement

The BSGDS for supporting the research (BSGDS Scholarship Award 2010 for Dr B. K. Dawett).

ENHANCED PRACTITIONERS

When I qualified 30+ years ago general dental practitioners tended to undertake a diverse variety of dental procedures in their own practices. Indeed to refer anything other than the most difficult wisdom tooth, (it had to be upside down and palpable on the inferior border of the mandible before referring) was seen as a personal sleight.

We now have inculcated a philosophy of referral within dentistry and the GDC's edict that one should operate within your own competency framework is excellent. I now find myself embracing this concept of referring patients to colleagues whose skills and training I have evaluated as good; I refer some endo, some perio, oral surgery and most implant placement.

Not all of my referrals are to specialists. Remember there is not, as yet, a speciality of implantology (although this is being considered by the GDC) and my orthodontic referrals were frequently to a generalist who specialised (not a specialist, a few letters, but an enormous difference) in ortho and confined his practice to this element of dentistry.

I have recently noticed that many of the specialists, like myself, are getting older and there are precious few specialist trainees to replace them over the next few years. Forgive my rather old figures but in 2003 there were 2,847 dentists on the specialist list of the GDC, of these 1,404 were over 50 years of age (2,710 were over 40 years of age). Eight years on, these very specialists listed as over 50 are nearing retirement.

More current GDC figures show 3,521 specialists but there is no evidence to suggest that the age spread has changed dramatically, only 258 specialists in 2003 had followed a training pathway that did not involve mediated entry and I predict that trainee numbers will not replace the retiring specialists. So where will we refer in the future?

One avenue might be Dentists with Special Interest (DwSIs); this scheme is beginning to gain momentum but it is a contractual arrangement NOT an acknowledgment of clinical status or competence. A competency framework is set out, but the achievement of the recognition of this skill level is dependent upon an NHS contract.

Implant dentistry may be setting a trend; the GDC is concerned about patient harm in the placement of implants and asked relevant bodies to outline suitable training standards. This resulted in the document 'Training Standards in Implant Dentistry' (FGDP); these were accepted by the GDC who then stated:-

'The GDC will also refer to the standards when assessing patient complaints against dentists who, allegedly, practise implant dentistry beyond the limits of their competence.'

This is an interesting situation, will the GDC consider in the future the same standards of training in other dental disciplines.

The standards document states, *'it is essential that the dentist carrying out this work has received suitable training, and has been assessed as competent to do it'.*

So could this become a general rule for future enhanced training; structured and assessed courses?

As one of the Course Directors of the FGDP's Diploma in Restorative Dentistry I believe the future of obtaining enhanced skills in dental disciplines and possibly filling the future referral needs lies not in day or weekend courses but in structured courses delivered by recognised educational bodies and having a skill assessment of some description. This calibre of training should then be recognised as appropriate training towards full specialisation.

But I would say that, wouldn't I.

Professor Mike Mulcahy
General Dental Practitioner
Professor Primary Dental Care
BChD FFGDP(UK) FRCS(Hon) FDS(Hon) MGDS LDS RCS(Eng)

Online Collation of Legislative Documentation and 'Aide Memoire'

Left to their own devices, most dentists will focus their CPD on the juicy clinical topics; implants, endo and the like, the aim being to achieve the highest standards in clinical care.

It is a fact of life however, that, behind the scenes, our 'general practices' have to be administered and run to a similarly high standard. Development in this area is rarely perceived as exciting and, without realising it, standards can slip. In my role as Vocational Training Adviser, I often inspect practices that deliver 'high end treatment' but, inadvertently, some do not comply with current legislation when one looks a little deeper.

It was with this in mind that I set about trying to make life a bit easier for the beleaguered GDP who, wanting to do the clinical stuff, still had to do the management bit.

The core skills outlined by the GDC and Faculty were the obvious place to start. But, as anyone who has amassed evidence knows, there is a huge time and work commitment, and it can be difficult to know where to start and what evidence to provide.

With a colleague I developed an online 'core skills package' to which the GDP could upload their evidence and reflect on how they complied. With this package the busy GDP could do the whole thing in bite size chunks, on line, whenever and where ever he/she wanted. Remote access for assessment or mentoring is a key feature – so there is no need anymore to print off portfolios or evidence!

Naturally, once the website template was perfected, it was then possible to use it to help others. The first choice was the overseas dentists: they have to show evidence of compliance with Foundation Training and interact with a CQC compliance site that reminds one of what needs doing and when.

Many smaller practices still have no manager and with ever increasing levels of regulation the busy GDP can be under pressure to keep tabs on everything from the cpd of the nurses to a fire risk assessment! Hopefully with some online guidance we can all get back to doing the interesting bits and make compliance simply a routine issue.

Nick Cooper
For further details, contact Nick Cooper: ncden@globalnet.co.uk

BSGDS ANNUAL CONFERENCE AND DINNER

THE PALACE HOTEL TORQUAY 5-7 OCTOBER 2012

Lecture Day – Saturday 6 October

I wish to make the following booking:		Number
2 nights DBB, attendance at the Lecture Day and Annual Dinner –	**£225**	
2 nights DBB incl. Annual Dinner (Accompanying person) –	**£175**	
Attendance at Lecture Day, Annual Dinner, B&B Saturday night –	**£150**	
Annual Dinner and B&B Saturday night (Accompanying person) –	**£100**	
Attendance at Lecture Day only, including lunch – BSGDS & FGDP Member –	**£50**	
BSGDS Member only –	**£60**	
Lunch on Saturday 6 October (for non-attendees at Lecture Day) –	**£16**	
Vintage bus trip to Greenaway (Agatha Christie's house)* – 6 October –	**£11**	
** Will not be back in time for lunch at Hotel.* **TOTAL**	**£**	
Less deposit (£50 per person)	**£**	
Balance due by Friday 28 September	**£**	

I enclose my deposit cheque – payable to *BSGDS Conference Account*.

Name: ..... Accompanied by: .....

Address including postcode: .....

.....

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Contact telephone: .....

Dietary requirements: .....

.....

Detach and return this application form to:

Dr Chris James (BSGDS Conference)

Lyme Bay Dentistry, Temple House, 63 Broad Street, Lyme Regis DT7 3QF

KSS Deanery and FGDP (UK) Invite you to:

The Vulnerable Adult Safeguarding and Oral Health

6th July 2012
10:00-16:30
Royal College of Surgeons of England

SPEAKERS
Sue Gregory
Anousheh Alavi
Graham Gilmour
Heather Lloyd
Vicki Jones
Debbie Lewis

COST
DCP - £30.00
Dentist - £60.00

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The day will cover:

- Information on vulnerability, signs of abuse and neglect and action to take in cases of suspected abuse.
- Oral Health issues for vulnerable people
- Care Quality Commission
  - Outcome 1 Respecting and involving people who use services
  - Outcome 2 Consent to care and treatment
  - Outcome 4 Care and welfare of people who use services
  - Outcome 7 Safeguarding people who use services from abuse
- GDC statement on Child Protection and Vulnerable Adults, (expansion of standards for Dental Professionals principle 1.8)
- Delivering Better Oral Health for older patients

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