



CDA BULLETIN

The Newsletter of the Commonwealth Dental Association
CDA is supported by the Commonwealth Foundation

MESSAGE FROM THE CDA PRESIDENT

Dr Brian Mouatt CBE
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What is CDA for? It is easy enough to subscribe to the platitude of better oral health and mutual support with a well-tuned turn of phrase but quite another to produce tangible results which can be measured. In these days of evidence-based science, justifying an existence becomes even more challenging. This was brought home to me when the Commonwealth Foundation turned down our request for the Triennial Meeting funding. In my innocence I had not imagined that something so important to us would not find the central support we had been led to expect. No, times are tougher now and for funders, prudence has turned to parsimony. The result for us is a stark reality, the Triennial Meeting we had planned for May 2003 in Manchester UK will not be possible; we have a problem.



One solution for us, upon which I am actively working, is to look to the new FDI World Dental Development Committee (WDDC) for some symbiotic support. WDDC is planning to hold a meeting on oral health development issues in Dar-Es-Salaam, Tanzania later in the year. This is very much our area of interest and one where we have an important contribution to make and what I believe CDA is really for; so with the blessing of the Executive Committee our plans are to hold our Triennial in tandem with WDDC. Sorry to those who love Manchester (both of you!) and lets go to Africa!

Speaking of the Executive Committee and taking a hard look at some of our longest serving members one cannot escape the harsh reality that chronologically and metaphorically, if not also dentally, we are getting long in the tooth. Where are the young lions to bring new vigour and life to CDA? It's time the old guard took a rest. The Triennial is your chance – think now how to help to make the elections to office real and revolutionary. New blood will bring new energy and purpose – get to the hustings and join in the fun.

Most of all we need your feedback. The brightest light on our horizon recently has been the very welcome decision of the Canadian Dental Association to join us. This is especially encouraging given Canada's magnificent track record of assisting the underserved in all matters of health. It is of course the home of the Commonwealth of Learning where we are in active participation. Australia and New Zealand – where are you?

STOP PRESS

CDA 4th Triennial Meeting Change of Venue and Date

As mentioned in the CDA President's Message, the CDA 4th Triennial Meeting will not be held in Manchester, UK, but instead in Dar-Es-Salaam, Tanzania, in 2003.

Further details to be announced later

EDITORIAL

A Part of All of Us *Professor Martin Hobdell, Editor*

As this edition of the *CDA Bulletin* goes to press so New York begins to mark the harrowing events of September 11th last year. Although for many in the Commonwealth these events may have seemed remote they impacted not just New Yorkers or Americans in general but all humanity, no matter what moral reference point the accident of birth, faith, gender, ethnicity or experience afford us. The 20th century was marred with such increasing acts of violence and moral outrage, last year's tragedy was a continuation this cycle and an inauspicious start to the new century¹.

Yet issues, more familiar in other parts of the world, of more subtle, less obvious attenuated violence, like starvation, abject poverty and the gross disparities in health between rich and poor, raise questions of equal moral gravity that remain sometimes forgotten and almost never resolved despite strenuous efforts by the Commonwealth Heads of Government, the UN and other Agencies. However without resolving these and related issues, it seems likely that the world is condemned to a continued cycle of violence that expresses the frustration and anger over the lack of universal social justice. That ultimate success has so far eluded the efforts of all does not mean that nothing has been achieved or that efforts should not be sustained. Rather it underscores the urgent necessity for all of us to seek solutions, working at our local level, for it is here that our common humanity is most easily expressed and understood.

That this somber moment inspires reflection on issues of morality and ethics and their importance in family, community and professional life is not sur-

prising. And in this context it seems wholly appropriate therefore that Dr. Thurairatnam reports (page 12) on a joint Commonwealth Medical, Lawyers and Dental Associations' meeting with the Royal Commonwealth Society in a *Commonwealth Medico-Legal Conference* in Kuala Lumpur early next year.

In a similar manner Dr. Mouatt, CDA President, in discussing the issues of evidence-based dentistry, is highlighting a practical way in which dentistry can be practised more ethically. By recommending the use, so far as is known, of those practices that are associated with the highest levels of efficacy and efficiency will patients' best interests be served. We should avoid anything less. The implication is that all of us must keep-up with the literature, and those engaged in research have a duty to work at the evaluation of the practice of dentistry in all its aspects and teachers need to base their teaching on the best evidence. A critical element of ethics is after all *truth telling*.

¹Glover, J. *Humanity – a moral history of the twentieth century*. New Haven, Yale University Press, 1999.

NEW CHIEF DENTAL OFFICER FOR THE UNITED KINGDOM

Dr Brian Mouatt, President of CDA, welcomed the appointment of Professor Raman Bedi to this important post. He said: "I was delighted to learn of Raman Bedi's appointment his long experience in transcultural studies and his overt-



enthusiasm for the CDA and its aims, bode well for the future. CDA sends its congratulations to him on his appointment and will give him its utmost support to the many difficult tasks which no doubt lie ahead".

Professor Raman Bedi will take up the appointment on 1 October 2002 from Dame Margaret Seward who retires at the end of September. The CDA would like to thank Dame Margaret for the support she has given them and wishes her well in her retirement.

FROM YOUR TREASURER

Over recent years the Commonwealth has moved away from an organisation centred on the United Kingdom to a matrix of organisations and individuals stretched across all the Commonwealth countries participating in dialogue and communication. And so it is with the Commonwealth Dental Association. Part of this dialogue and communication must take place at our Triennial Meeting next year, which your Executive is in the throes of planning. For it to be a successful meeting we need to ensure that we have sufficient funds to cover all our costs. We are not a rich organisation and have very little funds in our reserves so it is more important than ever that our member associations and our friends across the world pay their subscriptions when they fall due.

Many of you have paid – and I am very grateful – but many have not so may I please ask that you send your subscriptions as soon as possible. In that way you will keep me (and Julia, our hard working Administrator) happy but, more importantly, you will be helping to ensure the success of our Triennial Meeting.

Just as a reminder to the *Friends of CDA*, Individual Members' minimum contribution is £10 and Corporate Members £100. If you are not a *CDA Friend* already and would like to join, please contact:

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Thank you.
John Hunt, CDA Treasurer

CONGRATULATIONS

CDA would like to congratulate Tom Macadam OBE who was awarded the Order of the British Empire (OBE) in The Queen's Birthday Honours, for his services to Dentistry and to the General Dental Council. Tom Macadam, from Scotland, is a former Deputy to the President of the General Dental Council and a member for 25 years. He has been a member of the British Dental Association for over 30 years.

NEW PRESIDENT OF THE BRITISH DENTAL ASSOCIATION

Professor Ian Benington OBE was installed, on 2 May 2002, as the new President of the British Dental Association at this year's 2002 British and Irish Dental Associations' Annual Conference in Belfast.



Prof Ian Benington with the President of the Irish Republic

Ian Benington is currently Professor of Dental Prosthetics and Dental Materials. His previous appointments comprise : Director of the School of Dentistry, Queens University, Belfast (1989-1998); Consultant in Restorative Dentistry/Hon Lecturer Glasgow Dental Hospital & School (1972-1978); Senior Registrar, Dental Prosthetics, Eastman Dental Institute, London (1965-1972). He is a member of several Professional Societies.

CDA sends its warm congratulations to Professor Benington on his appointment and wishes him a happy and successful year.

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CDA Centennial Meeting

Dr Victor Eastmond

On this occasion, the acronym CDA refers to the Canadian Dental Association, which celebrated



*Dr R Salois, Dr G Sweetnam, Dr V Eastmond
(left to right)*

its one hundredth anniversary in conjunction with the Quebec Association which celebrated its 31st anniversary. The meeting took place at the Conference Centre in Montreal from 25-29 May 2002. It was an event which was supported by the Commonwealth Dental Association through the attendance of its Immediate Past-President, myself. Other dignitaries in attendance included Dato Dr A. Ratnanesan, President of FDI and also a Past-President of the Commonwealth Dental Association; Dr Peter Swiss, President of the British Dental Association and Dr Gregory Chadwick, President of the American Dental Association.

The first two days were devoted to *Hands-On* pre-convention courses in a variety of specialities for delegates who wanted to upgrade their knowledge/skills. On Sunday 26 May my wife and I attended a VIP reception, at the invitation of the president of CDA, Dr George Sweetnam, at the Hotel Intercontinental. It was at the reception that I was able to present a gift to Dr Sweetnam. The sumptuous Gala Dinner was well attended in the Conference Centre and was punctuated with a variety of entertainments that included *Step-Dancing*, Frank Leahy on his violin, an Ariel Acrobatic display, Three's Company Plus group and a dance band. The CDA Presi-

dent, Dr George Sweetnam, gave an official welcoming address and this was followed by Dato Dr A Ratnanesan (President of FDI) and Dr Robert Salois, President of the Quebec Dental Association. Both the reception and the dinner allowed for the meeting of new and old acquaintances and information relating to the Commonwealth Dental Association was disseminated. Many individuals requested information on the Commonwealth Dental Association and thereafter demonstrated pleasure and support for the CDA joining the Commonwealth Dental Association. I was honoured to be given a book entitled 'A century of service' by the author, Dr Ralph Crawford as a memento of the meeting and a reminder of the past century of the CDA.

Monday 27 May, started with the official Opening Ceremony at 8.00am. and the feature address being delivered by Marc Garneau, a Canadian astronaut. The CDA President, Dr George Sweetnam and Dato Dr A. Ratnanesan, President of FDI also welcomed the delegates. Most of the official proceedings were done in both French and English with simultaneous translation facilities being offered to persons who were not bilingual. The academic programme commenced at 8.30 a.m. each morning and concluded at 4.00pm. for the next three days. The programme, which was very varied, featured many prominent speakers. The Organising Committee must be complimented for maintaining punctuality of such a large conference, an average of ten lectures being delivered simultaneously during each session.

Dr George Sweetnam (President of CDA) and Mr George Weber (Executive Director) invited myself, Dr Gregory Chadwick and

other Executive members of CDA for dinner on the Monday evening at the Saint Denis Club. Cocktails in the Montreal suite of Hotel Intercontinental preceded the dinner. The venue for the dinner was exclusive with valuable art collections on show. It was at this occasion that both Dr Chadwick and I were able to thank the hosts for the hospitality I also had the pleasure to invite the Canadian Dental Association to attend, assist and participate at the triennial Commonwealth Meeting scheduled for 22-24 April 2003. It is instrumental that the CDA is now the newest member of the Commonwealth Dental Association. Their participation is one more step in achieving that ultimate goal of the Commonwealth Dental Association: the provision, attainment and maintenance of better oral health and dental health services for the peoples of the Commonwealth.



*Dr V Eastmond, Dato Dr A Ratnanesan,
Dr T Breneman, Dr J Cottrell (left to right)*

In conclusion, I was happy to be the representative of the Commonwealth Dental Association at the CDA Centennial Meeting and must continue to praise their organisational ability, their hospitality and their most picturesque country. I look forward to seeing their delegation at the Triennial Meeting due to take place in 2003 where, I am sure, our Commonwealth Dental Association will be able to reciprocate. I thank the Commonwealth and Canadian Dental Associations for the financial support given in making my participation possible.

INNOCENCE OR INFORMATION

The Importance of the Evidence Based Movement

Dr Brian Mouatt CBE

"Faith is the substance of things hoped for. The evidence of things not seen for by it the elders obtained a good report"

The Epistle of St. Paul the Apostle to the Hebrews; Chapter 11, verses 1-2

Life does not get simpler. There was a time when students listened with appropriate reverence, if not awe, to the professorial words of wisdom on the range of topics, which in those days comprised the dental undergraduate course. It has to be admitted that testing diet now seems a piteous thing when compared to the crowded and complex curriculum of today. No longer is the student permitted to record the savings of his teacher, memorise and regurgitate a reassuring catechism in order to pass his professional exams with flying colours. Heaven preserve us, he is now required to think. What is more he must learn how to learn. Problem solving approaches, researching the literature, lateral thinking and the assessment of the quality of evidence are all part and parcel of the modern students' modus operandi.

What has brought about this change? It is a change which is sweeping through the whole medical educational infrastructure from undergraduate studies through the postgraduate and continuing professional development initiatives.

The history of progress throughout the ages is one of continual discovery amid the subsequent implementation of novel treatments or techniques that arise from the application of this new knowledge. This methodology has stood the test of time and indeed has evolved. From the medical perspective at first, the determination of what constitutes effective treatment was learned empirically or by trial and error. Knowledge and skills were passed from master to apprentice. Those who were most successful grew rich by results

and reputation. This is a simple and well-understood process, depending upon cause and effect. It is attractive for its purity and, of course, is beloved by patients who for the most part stubbornly refuse to believe in their own mortality, clinging to the belief that the writing of a prescription is the essential first step to total cure. If only life were like that!

Unfortunately the frailty of human nature intervenes. Some cures are not cures at all and may be totally ineffective, worse they may be harmful. Some techniques seem to work in the hands of some skilled operators but when colleagues emulate their efforts, strangely, the reported results seem more elusive. Some techniques are applied more in hope than certainty. Many are applied without the benefit of evidence to show that they are indeed appropriate or useful.

In a world where the costs of treatment escalate at a worrying rate and research and development costs are no different, there is now abroad a much more critical climate of appraisal of the tools, tinctures and techniques we use to care for our patients. Added to this new scrutiny is the rise of consumer interest in getting results at the same time as getting value for money. As consumers' discretionary spending is ever more challenged by the rising cost of treatment, the greater will be the interest taken in what exactly the benefits turn out to be. Nor is it just the patients who exhibit this enhanced interest in where their money goes. Any provider and funder of health care worth his or her salt is looking far more critically than, say, a decade ago at the cost benefit issues and how they affect the priorities which finite budgets require.

It is now time for us to examine more closely what constitutes respectable and reliable evidence of clinical effectiveness and applies more robust criteria when reviewing the range of treatment options open to us. We can be encouraged by the fact that to do so is fashionable. Evidence based

medicine is rapidly becoming an indispensable management tool. It is also true that we should be alerted to the fact that others may begin to do it for us, should we not take account of these developments. Irrational fear of the new is a familiar reaction in human behaviour; the antidote is a better understanding of the change. In this we have allies. Stimulated by the work of Archie Cochrane, the discipline of systematic reviews of evidence is now commonplace.

There are a number of excellent new initiatives to help us through this new flood of information based technology. One outstanding example is the new publication *'Evidence Based Dentistry'* edited by Alan Lawrence and published by the British Dental Journal. As Alan Lawrence says:

"For both the professional and the patient, the central question is therefore how can we get the right information and conversely avoid getting the wrong material. We could wait for our practice experience and professional consensus reports to offer solutions. It is clearly better that we put the methods of evidence-based health care into practice now".

Evidence-based Dentistry (EBD) should help provide this information as it is based on the methods of evidence-based healthcare. It is defined as:

"The conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients."

The methods of EBD are relatively straightforward, and relatively unbiased. They are:

- ◆ Ask evidence-based questions (*hypothesis formulation*);
- ◆ Search for the current best evidence (*e.g Medline, Cochrane Databases, or Embase*);
- ◆ Critically appraise the information (*Is the information valid, and important?*);
- ◆ Apply this information to your patients' problems or questions (*e.g in the areas of diagnosis, prognosis, treatment, and potential harm*).

EBD has started well. No less than twenty-three articles appear. The first four of these give a most useful introduction to the evidence based philosophy. Others cover a whole range of clinical issues of the moment, ranging from a summary of the work of Robinson and Smith² drawing attention to work that shows that the raising of a lingual flap increases the risk of nerve damage, to a meta-analysis by Lodra et al³ which shows, without doubt, that sealants are an effective method of reducing dental caries. A piece that is as revealing as it is useful by, Richards⁴, explains the Scientific Citation Index rankings and the number of controlled trials and systematic reviews published by the top 39 journals in the index. Not surprisingly, perhaps, the Journal of Dental Research scores highest. Our own British Dental Journal comes in at thirty-first. All in all this is a very welcome development.

Others are in the forefront of producing the systematic reviews, meta-analysis and assessments upon which the whole philosophy is based. The NI-IS Centre for Reviews and Dissemination, based at the University of York is a case in point. It aims to be an update on the effectiveness of health interventions for practitioners and decision-makers in the NI-IS. It is produced by researchers at the Centre, based on high quality review of the evidence. It extensively peer reviews by subject area and practitioners. The Centre itself is funded by the NI-IS Executive and the UK Health Departments. Its publication *'Effectiveness Matters'*⁵ has already covered two major subject areas of dental interest. The first asks the question "Is the prophylactic removal of third molars justified?" The second reviews dental restorations and comes to valuable pragmatic conclusions.

The former question is an excellent example of the value of the approach. This is a question which has been troubling providers and purchasers of oral surgery services for many years but until this

work was undertaken no definitive answer was available. The conclusions of the review were uncompromising:

- ◆ *Third molar surgery rates vary widely across the UK;*
- ◆ *Around 35% of third molars removed for prophylactic purposes are disease free;*
- ◆ *Surgical removal of third molars can only be justified when clear long term benefit to the patient can be expected;*
- ◆ *It is not possible to predict reliably whether impacted third molars will develop pathological changes if they are not removed;*
- ◆ *There are no randomised controlled studies to compare the long term outcome of early removal with retention of pathology free third molars;*
- ◆ *In the absence of good evidence to support prophylactic removal, there appears to be little justification for the routine removal of pathology free third molars;*
- ◆ *To ensure the appropriate treatment, referrals and waiting lists for the surgical removal of third molars should be monitored through a process of audit.*

Advice of this quality and authority is clearly of the greatest value in improving services to patients. It is, as readers of the author's generation will know, a far cry from the received wisdom passed on by our elders, where faith substituted for 'things not seen'.

The evidence-based movement has got off to a good start. It is not the answer to all our woes but if it improves the quality and effectiveness of the services we are able to provide for our patients it will be seen as a very significant step forward indeed. What could make more sense than using our pitifully small resources only on things that actually work!

References

- 1 *Evidence Based Dentistry, Vol 1, No 1, 1998, ed Lawrence A; suppl Br Dent J, London ISSN 1462-0049*
- 2 *Robinson PP, Smith KG, Br Dent J: 1996; 456-461*

3 *Lodra JC et al. Factors influencing the effectiveness of sealants, a meta-analysis: Community Dent Oral Epidemiol. 1993; 21: 261-268*

4 *Richards D. Which Journals Should You Read to Keep Up To Date?: Evidence Based Dentistry, 1998; 1: 22-25*

5 *Effectiveness Matters, NHS Centre for Reviews and Dissemination, Univ York, 1998: 3; issue 2*

PRE-WHA MEETING

Dr Robin Wild; Julia Campion

This annual meeting of Commonwealth Health Ministers, held in Geneva on the eve of the World Health Assembly, took place on Sunday 12 May 2002 under the auspices of the Conference Director, Ms Nancy Spence. It was chaired by the Hon Alesana Seluka, the Minister of Health for Tuvalu, and was attended by Ministers of Health and their delegations from 43 Commonwealth countries. Observers comprised representatives from the World Health Organization (WHO), Pacific American Health Organisation (PAHO), FDI World Dental Federation, health-related Non-Governmental Organisations (NGOs) and other international organisations. From the Commonwealth Dental Association (CDA) were Dr Robin Wild (representing the CDA President who was unable to be present), Dr S Prince Akpabio (CDA Executive Secretary) and Julia Campion (CDA Administrator).

Among the items on the agenda were:

- ◆ *Human Resources for Health.*
 - ◆ *Commonwealth Code of Practice for International Recruitment of Health Workers.*
 - ◆ *Women and Health.*
 - ◆ *HIV/AIDS.*
 - ◆ *Diet, Physical Activity and Health.*
 - ◆ *Deliberate use of Biological and Chemical Agents to cause harm.*
- There were 2 presentations on *Global Alliance for Vaccines and Immunisation* and *The Global Fund to Fight AIDS, Tuberculosis and Malaria*.

There was considerable and justifiable criticism of the British National Health Services's recruitment of health professionals from

other parts of the Commonwealth, particularly those parts that could ill-afford to lose what trained staff they had. The British Government defended their position weakly by saying that antidiscrimination laws in Britain meant that they could not discriminate against applicants from other parts of the Commonwealth. No conclusion on a code of practice had been reached at that meeting.

There was also a detailed debate on setting up an Information Hub for Traditional and Complementary Medicine. This debate was proposed by the Government of Malaysia and after a great deal of discussion it was agreed that Malaysia should set this in train.

The afternoon session was opened by Dr Gro Harlem Brundtland who spoke on the *Priority Health Issues in the Commonwealth and Exchange of Views on World Health Assembly*, and took questions. Ms Nancy Spence thanked Dr Brundtland for having come to address the Commonwealth Health Ministers and called upon Dr Akpabio who presented a bouquet of flowers to her.



Dr Gro Harlem Brundtland and Dr S P Akpabio

As the afternoon's deliberations came to a close Dr Akpabio thanked the Hon Annette King, Minister of Health for New Zealand, for having hosted the 13th Commonwealth Health Ministers' Meeting in Christchurch (25-29 November 2001).

After the day's proceedings, the Commonwealth Health Ministers and other delegates enjoyed the relaxed atmosphere of the Reception hosted by the Commonwealth Dental Association and the International Life Sciences Institute (ILSI). The CDA is very grateful to ILSI for their support in enabling this Reception to take place.

A 'THANK YOU' TO DR SAMUAL JOSIAH THORPE Regional Adviser for Oral Health to the World Health Organization for Africa (WHO/AFRO)

Martin Hobdell, Editor

Sam Thorpe, as he is known to his many international colleagues and friends has served as the Regional Oral Health Adviser at WHO/AFRO since 1990. He retires from this position at the end of September 2002. He is well known to the Chief Dental Officers throughout Africa as he served in that capacity for his own country, Sierra Leone, from 1980 to 1988, having begun work for the government as a Provincial Dental Officer in 1969. He also taught preventive and community dentistry, before joining WHO/AFRO.

His greatest contribution to Oral Health in the Commonwealth has been made through his work with the World Health Organization. Not only has this been in his position as Regional Adviser, but earlier on, first as a member of the WHO Expert Committee on Pre-Practices for Oral Dis-eases (1983), then as a Temporary Advisor to Oral Hygiene Practices, with the World Health Organization. Not only has this been in his position as Regional Adviser, but earlier on, first as a member of the WHO Expert Committee on Pre-Practices for Oral Dis-eases (1983), then as a Temporary Advisor to Oral Hygiene Practices, Malawi, Nigeria, Tanzania amongst other countries WHO Short Term Programmes in the African Region (1988/89). The latter post led to the creation of the post of Regional Adviser for Oral Health for the African Region to which he was subsequently appointed.



His singular most important contribution in this post has been the development of a New Regional Strategy for Oral Health – something that not only benefits the Commonwealth countries in the Region but all countries within and outside the Region because of its pragmatic, evidence based approach. Since its adoption in 1998 by the Regional Ministers for Health, Sam has continued to work for its implementation. His vision is of a strategy that really is implemented and that above all makes a difference – something that does not just exist on paper. In April, for example, he spoke strongly in favour of there being an association for dental education in the region in order to strengthen dental education and research. This was at the first ever meeting of all the educational institutions for oral health in Africa, both north and south of the Sahara. Sam was the organiser of what was an extremely productive meeting that will have lasting effects in the Region (see page 9). Likewise his success in establishing WHO Collaborating Centres at the University of the Western Cape in Cape Town, South Africa and the Muhimbili University of Health Sciences in Dar es Salaam, Tanzania and in reviving the International Collaborative Centre for Oral Health in Jos, Nigeria continues to benefit many countries in the Region.

He will be missed in Brazzaville, where WHO has finally returned after some years of 'refugee' status, which has been hard on all WHO officers, including Sam and his family, for he contributed not only to the oral health sector but was an active member of the secretariat for the annual Regional Meeting of Health Ministers, where his critical writing skills were highly valued.

It is time to say: 'Thank you Sam and every good wish for the future. We hope that you will find a way to continue to be involved in helping improve oral health throughout the world'.

ADOPT-A-DENTIST A Success Story

Jo Daly BDS DGD(UK) RCS

It's freezing cold and pouring with rain outside and the patients are growling about the weather and when will summer come. You're up to the eyeballs with patients, practice problems and paperwork. This is when you wonder what it would be like working in another country and if they have the same or worse problems with bureaucracy and red tape? Wouldn't it be lovely to work in a place where the sun is always shining?

By joining the Commonwealth Dental Association (CDA) and then the Adopt-a-Dentist scheme you have a good chance of finding out the trials and tribulations of life as a dentist in such places as Fiji, India, Kenya, Nigeria, Seychelles, Tanzania, Zambia

and Zimbabwe. The scheme enables individual dentists to be in touch, and enjoy professional interaction between colleagues, exchanging experiences and giving each other friendly links across the vast distances of the Commonwealth.

I signed up to the scheme December 2001 and was given the e-mail of Dr Charles Ilesanmi, a 35 year old dentist in Nigeria. We soon became regular correspondents and I found Charles to have a consuming passion for information about all parts of dentistry, especially orthodontics. He qualified in 1990 and now has his own surgery (Topaz Dental Clinic) in Kaduna, a town 8 hours' drive or a one and a half hours flight from the capital Lagos.

Training is fashioned after the British style but there is very little postgraduate follow up with the Nigeria Dental Association not as

organised as the BDA. For CPD, journals, books, materials and equipment he looks to Europe and America. The obvious limitations are a serious lack of servicing for equipment as well as spare parts.

His main problem is being so far from the capital, where most of the dentists are. There is no orthodontist in Kaduna and only 3 practices for 3-4 million people. However there is still the difference between need and desire just like here. Patients don't want treatment unless they have to and the HIV problem puts them off going.



Jo Daly (front row 2nd from left) and her team with Charles Ilesanmi (centre back)

Charles says they all want to inspect the autoclave and see gloves being worn before they receive treatment.

Due to the lack of an orthodontist Charles signed up for a Truitt course in London in April and we made arrangements for him to visit and stay with me in the North.

This was slightly difficult at first as we had decided to meet at Kings Cross station due to the London marathon being on and then get the train out of London where I could meet Rob (my partner) and drive North. Neither of us having seen each other made for some problems - walking up to a stranger of the opposite sex and asking their name in a well known pick-up area, made us soon realise we could be in serious trouble. A timely phone call and quick assessment of the area found a

meeting point and we found we'd passed each other a few times but not realised who was who.

It was Charles's first visit to England and he saw a lot of the countryside - as well as rain - on our drive up to Darlington. One of Rob's first duties was to find him a jumper!

On the Monday he came to the practice and watched the sessions with myself, my associate, Alison James and VDP Leila Hankin. He trawled through the dental catalogues like a schoolboy in a sweetshop looking for materials to order and take back home. We also found videos and books, which we no longer used and spare educational material to take back.

During a practice meeting he joined in our regular fire drill and CPR routine with a rescusci Annie as we trained a new member of staff. There are no guidelines, procedures or equipment for emergency situations at home.

He then went on to tell the team about his family - wife Titi a medical nurse and two daughters, Tula 7years and Abeki 3years - and practice, showing us photographs of his clinic and also pictures of schoolchildren on a visit to see him.

He was impressed by the number of years the girls had been with me, as he found it a problem getting staff due to many girls getting married at 15, having babies and stopping work.

We talked about the problems of equipment breaking down and how he would maybe have to wait for days if there were problems with the chair or compressor. We realised that some of the modern equipment that we now have would be entirely useless in Nigeria and that the old hydraulic chairs are ideal. Charles started with a locally fabricated chair/spittoon/

sirobox before he was able to buy the old dental units he is now using.

Charles noticed how patients - in the main - kept to their appointments. He is trying to educate his patients on the benefits of an appointment system. Most don't like booking an appointment and only attend when in pain, so attendance is unpredictable. They often walk in expecting all to have their treatment there and then and not wanting to return - sometimes we have the same problem. Because of the unpredictability of patients and their ability to pay (there are no dental insurance schemes) there is some stress working in a privately based practice and this can only work in a city. Most dentists elect to work in salaried employment in state and federal government clinics. Better security and prospects with the ability to run their own clinics after closing hours leaves very few like Charles in the private sector.

Charles had a root-filled tooth that had gone dark and I offered to bleach it with Opalescence-Xtra. He was surprised at how quickly it worked and also impressed. In Nigeria it is expensive to crown a tooth and most root treatments in anterior teeth are due to trauma. This gave him a much easier option for treatment.

Rob took him to visit denture technician Derrick Illingworth and to the local orthodontist Dr Ian Lund where he stayed for the afternoon and watched him assess patients for orthodontic treatment.

A visit to local colleague Dr Simon Allum gave him an insight on implants in general practice. He was also taken to see one of the first English dentists to teach in Nigeria, Peter Lawrenson who actually worked in Kaduna long before Charles even thought about dentistry. Peter, now retiring from the sport, gave him a complete set of golf clubs and waterproofs to take home as there is a golf course

close to the practice and a patient has been trying to persuade him to learn.

Charles also met other colleagues for meals and was impressed by the co-operation and interaction amongst dentists in the area as this is not possible in Nigeria for many reasons, including the worry of poaching patients.

Charles was relieved however that despite all his limitations he wasn't lagging far behind in giving his patients the ideal service with suitable cross-infection control.

Rob was taking equipment donated by various practices in the area down to Dentaids warehouse near Southampton, before dropping Charles on the train to London before his course on Friday. This meant that Charles could meet Peter Gardner and discuss Dentaids work abroad. He explained the various problems of treating people in the villages and shortage of equipment. He said it could take days to get to some areas and it was difficult to get to them even by car. Also in these villages 'quacks' who have barely any knowledge of dental health would provide treatment leading to problems of infection. He also thought it important that local professionals/volunteers be involved with supplying aid to those in need.

The orthodontic course, while giving him a greater insight into treating patients, has made him realise that it is still going to be limited to simple cases, as the cost and extra courses needed, is prohibitive for protracted treatments.

Charles returned to Nigeria heavily laden with supplies he had ordered, articles and magazines books and of course the golf clubs!

He will be back in England to attend a Community Dentistry course in August, a subject which also comes low in priority in Nigeria but which he is eager to encompass.

All during Charles's visit I was impressed with his enthusiasm for dentistry. Despite the problems he had to encounter he was totally in love with his chosen career and ready to find ways to improve his own postgraduate education and provision of services to his patients.

In this regard I think his eagerness far surpasses the general one found among dentists working in the NHS here, which Charles sees as an improvement on his own situation. I myself found that the patients sounded the same in their attitude to dentistry as over here. As for the grass being greener on the other side - I think I'm probably better with the Devil I know!

This is obviously just the start of what we both hope will be a long relationship despite his remark of me being his 'dentist mother'!

Editor's Note: Lagos is the former Federal Capital and remains the economic centre of the country. Recently Abuja became the Federal Capital with the main Government Ministries and the Parliament Building being moved there.

To get involved with the Adopt-A-Dentist scheme e-mail [Julia Campion at JuliaCampion@cdauk.com](mailto:JuliaCampion@cdauk.com) or write to her at
Julia Campion
CDA Administrator
13 Rodney House
Pembroke Crescent
London W11 3DY
UK

NEW APPROACHES IN ORAL HEALTH TRAINING AND EDUCATION IN AFRICA

Dr Neil Myburgh

Head, WHO Collaborating Centre for Oral Health, University of the Western Cape, Cape Town, South Africa

A very successful World Health Organization Consultative Meeting on *New Approaches in Oral Health Training and Education in Africa* was held April 23-26 2002 in Cape Town, South Africa. For the first time the Deans and heads of dental education facilities throughout Africa came together to discuss ways in which their institutions could assist in the implementation of the Oral Health Strategy of the WHO African Region and in particular to consider relevant new approaches to oral health training and education for the level and type of care needed in Africa in the 21st century.

Four specific objectives addressed were:

- (1) Identify ways to re-position training institutions through innovative approaches and updated curriculum for oral health care required in the African Region.
- (2) Explore the extension of research collaboration and other research initiatives to address African oral health problems and opportunities.
- (3) Establish a network linking the training institutions among themselves and with WHO/AFRO.
- (4) Consider establishing an African Oral Health Education Association.

Participants included the deans of 22 university dental training institutions and heads of 6 dental auxiliary training institutions, 9 selected experts and 3 observers from related oral health institutions. Professor UME Chikte was elected to chair the meeting, supported by Professor D Bouzianne (Deputy Chair), and Professors M Sembene and EO Ogunbodede as Rapporteurs. The reporting process was facilitated by a Secretariat of Professor S Naidoo and Dr N Myburgh. The working methods involved formal presentations and discussions at plenary sessions as well as working group sessions. The meeting was organized by WHO-AFRO together with the WHO Collaborating Centre for Oral Health, University of the Western Cape, Cape Town, South Africa.

Several world-renowned specialists in oral health addressed the meeting on topics ranging from innovation in dental education, research priorities, collaboration and partnership, funding and information technology, to the role of a future association of dental educators in Africa.

At the conclusion of the meeting several important recommendations were agreed upon.

(1) Situation Analysis: Establish a database of training institutions including data on: Entry and exit levels; Type of personnel trained; Quantity of personnel trained; Learning methods used; Exit com-

petencies. A draft document on core competencies with an emphasis on prevention was circulated for consideration and discussion.

(2) Research Collaboration: Establish an African database of research resources and infrastructure, disease profiles, current research efforts. It was also agreed that the group should: Identify common and collaborative research interdisciplinary teams; Identify publication opportunities for research from the region; Identify and strengthen existing journals from the region; and Identify current and potential funders for joint research initiatives.

(3) Information & Exchange:

- (a) Establish an electronic listserve to facilitate communication between all the institutions in the region;
- (b) Strengthen existing relationships between institutions and individuals in the region through collaborative postgraduate and undergraduate education, joint research initiatives, student and staff exchange and sharing of curricular components;
- (c) Establish shared courses in research skills training for teachers, educational method for teachers, leadership, management and IT training.

(4) An Association: There was unanimous agreement to establish an African Oral Health Education Association. A steering committee was formed comprising persons covering geographic, linguistic and gender diversity. The brief of the steering committee is to draft a constitution, carry out tasks arising from this meeting, consult with participants, liaise with WHO-AFRO, raise funds for the new Association, organise a 2004 follow-up meeting and widely disseminate the report of this meeting.



WHO/AFRO & University of the Western Cape Dental Education Meeting Participants

DENTAL DIGEST
Abstracts of articles from
other journals

Dry Mouth

Dr D Y D Samarawickrama

*Adapted from:
Oral Diseases 8:177-179(2002)
Guest Editorial*

Saliva performs several important functions: lubrication, hydration, buffering, mineralisation, facilitating taste, tissue coating and antimicrobial activity. In order to fulfil these, saliva has a complex structure. There are several families of salivary molecules, each with multiple members. It is now known that the majority, if not all saliva molecules are multifunctional. Many molecules have overlapping functions, for example, mucins and amylase interact with *viridans streptococci*.

It has also been recognised that a particular salivary component may be protective or harmful depending on its site of action in the mouth. Amylase interacting with *viridans streptococci* to facilitate their clearance from the mouth can be protective. However, amylase adsorbed to the tooth surface can promote adherence of the very same bacteria and also digest dietary starch to maltose. The latter in turn can be used by bacteria to produce acid resulting in demineralisation.

Xerostomia or oral dryness is a clinical manifestation of salivary gland dysfunction affecting many people. These individuals sip liquids frequently to alleviate the discomfort associated with reduced saliva. Dry mouth is rarely associated with systemic dehydration and consumption of water excessively does not overcome oral dryness. On the other hand, frequent consumption of water can remove the mucus coating the oral surfaces and further increase the symptoms of dryness.

Dry mouth may be caused by several conditions like dehydration,

diabetes and diseases involving salivary glands such as Sjogren's syndrome. This syndrome has been reported in nearly every major country of the world. It typically affects women (90%) during the fourth and fifth decade of life. Isolated cases in children have also been reported. In addition, it is also one of the side effects of a wide variety of drugs such as antidepressants, antihypertensives, antipsychotics and antihistamines. It is one of the commonest complaints experienced by patients who have had radiotherapy of the oral cavity and head and neck region. However, the complaint of dry mouth may or may not be associated with decreased salivary gland function.

Xerostomia can lead to an increase in dental caries and periodontal disease, difficulty in chewing, swallowing and speaking and intolerance of dentures. It also makes patients prone to infection like candidiasis.

Radiation causes acinar atrophy and chronic inflammation of salivary glands. At present there is no treatment for radiation-induced xerostomia. Therefore, there are compelling reasons for sparing salivary tissue during irradiation.

No one form of treatment for xerostomia is sufficient. Only with a comprehensive regimen can a patient's oral comfort and function be improved and tooth loss from caries prevented. The treatment regime includes salivary flow stimulation, possibly changes to the patient's prescription and non-prescription drug use, selective use of saliva substitutes, recognition and treatment of oral candidiasis and a caries preventative regime.

If there is residual salivary gland function, there are systemic agents that can stimulate salivary flow. Oral administration of pilocarpine hydrochloride (Salagen) 5 milligrammes, 3 times per day is effective in improving salivary flow. Pilocarpine tablets are licensed

for the treatment of xerostomia following irradiation for head and neck cancer and for dry mouth and dry eyes in Sjogren's syndrome. In certain conditions, close medical supervision is necessary e.g. asthma, cardiovascular disease, biliary tract disease, peptic ulcer, hepatic and renal impairment. Pilocarpine has unpleasant side effects, blurred vision being one of them. As these are effective only in patients who have some residual salivary gland function, they should be withdrawn if there is no response.

Use of saliva substitutes may become necessary to manage xerostomia when no means of stimulating saliva production is effective. A properly balanced product should be of neutral pH and contain electrolytes to make the composition similar to natural saliva.

Milk appears to have many of the chemical and physical properties of a good saliva substitute. In addition to moistening and lubricating the oral mucosa, milk is capable of buffering oral acids, reducing enamel solubility and contributing to enamel remineralisation. These properties are attributable to the high calcium and phosphate content as well as milk phosphoproteins that adsorb to enamel. Due to these factors, many patients might find milk as an effective saliva substitute.

It is clear that the main reason for using saliva substitutes is to improve lubrication and hydration of oral tissues and maintain oral health and function. However, there should not be any adverse effects when these agents are used.

DENTAL DIGEST
Abstracts of articles from
other journals

Lingual nerve injury subsequent to wisdom teeth removal – 5 year retrospective audit from a high street dental practice

Malden N J & Maidment Y G
Brit Dent J 193: 203-205 (2002)

Lingual nerve damage subsequent to lower wisdom tooth removal affects a small number of patients, sometimes producing permanent sensory loss or impairment. A number of surgical techniques have been described which are associated with lower incidences of distressing post-operative complications.

This paper reports an audit undertaken by the authors to establish how effective it is in relation to established nerve injury rates. The technique studied here has been used for the removal of mild to moderately impacted wisdom teeth for adults treated as outpatients in general practice using local anaesthesia.

In all cases a muco-periosteal flap was raised buccal to the lower third molar. The distal relieving incision was placed lateral to the retro-molar pad in such a position that all anatomical variants of the lingual nerve position would be avoided. An incision following the external oblique ridge would be safe in this respect. While the buccal flap was retracted the lingual tissue was retracted only to expose the occlusal aspect of the tooth or the superior aspect of mandibular bone covering the tooth or the crest of the lingual plate. No effort was made to raise or elevate the lingual muco-periosteal flap off the lingual aspect of the mandible.

If distal bone was removed, care was taken to cut from the lingual towards the buccal. If tooth section was performed, this was done as follows: the tooth was incom-

pletely sectioned with the bur and then Coupland's chisel placed into the cut and rotated to complete the division.

Tooth crowns were often removed early to allow continuation of bone removal distally under direct vision. Following tooth removal, sutures were placed according to the rule of "tight knots, not sutures" to avoid strangling an unusually placed lingual nerve.

In the 260 surgical extractions studied, a buccal soft tissue flap was raised in all of them, in 40% involving sectioning of tooth with bone removal and in 28% involving bone removal only.

Complications reported were: swelling 5.7%, bleeding 1.1%, post-operative pain 1.9%, infected socket 5.0%, trismus 0.8% and lingual paraesthesia 0.4% with full return to normal sensation within 6 weeks.

The temporary nerve damage incidence of 0.4% compares very favourably with that reported by others for bone removal with "drill no lingual flap" where the temporary nerve injury was reported as 0.8% and permanent injury reported as 0.3%. The only technique recording a lower incidence of permanent lingual nerve injury in the UK was the lingual split with lingual flap retractor technique, which is normally performed under intubation general anaesthesia.

The surgical technique described is associated with an acceptable low incidence of lingual nerve damage when considering its application in the general practice setting for mild to moderately impacted lower molars.

The fate of 1,587 unrestored carious deciduous teeth: retrospective general dental practice based study from Northern England

Levine R S, Pitts N B & Nugent Z J
Brit Dent J 193: 99-03 (2002)

This study has investigated the outcome of non-restoration of caries deciduous teeth by means of retrospective analysis of clinical case notes of 481 children regularly attending two general dental practices in Northern England. The age of initial diagnosis of carious teeth range from 1-12 years with the majority of the cavities (1,005), present by 6 years of age. In all 1,587 teeth were followed until lost from the mouth. Of these 12% were extracted because of pain and further 4% because they became painful and were treated leaving 84% that remained symptom-less until being lost. Final group of 74% teeth exfoliated without causing pain after a mean survival time of 1,332 days. The principal finding was that over 80% of carious and restored primary teeth remain symptom-less until natural exfoliation.

Pain is more significantly more likely to occur if caries was first recorded at a very young age. Pain was also more likely in molar teeth and teeth with multi-surface lesions. Perhaps the most surprising findings were that only 34% of the teeth considered to have the worse prognosis in primary molars with pulpal involvement at the age of 3 caused pain and that 60.4% of teeth with pulpal exposure painlessly exfoliated. If the 70 teeth that had no pain but were extracted were excluded, 74.6% of teeth with pulpal exposure exfoliated without pain. In this climate of evidence-based dentistry, information is needed on the consequences of leaving carious deciduous teeth unrestored. This paper provides some of that evidence to aid in the treatment planning of carious deciduous teeth in children receiving regular dental care.

NEWS FROM THE REGIONS

From the East, Central & Southern African Region

Professor Jacob Kaimenyi, CDA Advisor

Dentist Appointed to Head Kenya National Referral and Teaching Hospital: History was made recently when Dr Meshack Ong'uti was appointed the Director of Kenyatta National Referral and Teaching Hospital. He is the first dentist to be appointed into such a post since the inception of the institution 100 years ago. Dr Meshack Ong'uti holds a PhD in Oral and Maxillofacial Surgery from the University of London. The dental fraternity in East, Central & Southern Africa wish him the best of luck in this demanding task.

Kenya Dental Association Gets a New Chairman: In May 2002, the Kenya Dental Association held its Annual General Meeting and Dr Tom Ocholla was elected as its new Chairman. Dr T J Ocholla takes over from Prof J T Kaimenyi who had served the Association for 2 consecutive terms and left the Association's accounts very healthy. The East, Central & Southern African Region and CDA

wish to congratulate Dr T J Ocholla on his appointment and look forward to working with him closely. Dr T J Ocholla is a Senior Lecturer at the University of Nairobi, Faculty of Dental Sciences and a Specialist in Dental Radiology.

Kenya Launches its National Oral Health Policy: After hard work by a taskforce team chaired by Prof J T Kaimeny, Dean of the Faculty of Dental Sciences and Immediate Past Chairman, Kenya Dental Association, Kenya has recently formulated its National Oral Health Policy with the help of WHO (AFRO). This important policy was launched by the Minister for Public Health on 21 August 2002, at the Kenya Medical Research Institute. The occasion was also attended by the WHO Country Representative in Kenya; the Permanent Secretary, Ministry of Health; a large number of members of the dental fraternity as well as a cross-section of representatives from the dental industry. Kenya now joins the other 14 countries in Africa (WHO) who have formulated their National

Oral Health Policies. CDA takes the earliest opportunity to congratulate the Kenyan Government for this wonderful initiative and looks forward to its implementation as soon as possible, so as to improve delivery of oral health care in Kenya.

Professor J T Kaimenyi - Special CDA Advisor - Re-elected Dean, Faculty of Dental Sciences, University of Nairobi: The Faculty of Dental Sciences, University of Nairobi held its elections on 29 May 2002 and re-elected Prof J T Kaimenyi as its Dean to serve for another term of 2 years. Prof J T Kaimenyi is a Professor of Periodontology at the University of Nairobi and a Special Advisor for CDA. The East, Central & Southern African Region and CDA wish him good luck as he puts extra effort to strengthen the existing teaching programmes and develop new ones, especially those that will lead to several Masters Degrees in various dental disciplines, in a region where specialisations in dentistry are very rare.

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From the South East Asia Region

Dr T Thurairatnam

The Commonwealth Medical Association, the Commonwealth Lawyers Association, the Commonwealth Dental Association and the Royal Commonwealth Society for the first time ever in the history of the Commonwealth are jointly organising a *Common-*

wealth Medico-Legal Conference in Kuala Lumpur, Malaysia, next year, 17-19 January 2003. A distinguished panel of speakers, both local and foreign, has been carefully selected to discuss and challenge current ideas and practices in medical ethics within the Commonwealth countries. The 4 main topics of discussion will be:

- ◆ *Termination of Pregnancy: Medical and Ethical Dimensions*
 - ◆ *Assisted Reproductive Technologies: Boon or Bane*
 - ◆ *Doctors are not Gods*
 - ◆ *Medical Care for Persons in Detention*
- Delegates should book their own accommodation and bear their own accommodation and travel expenses.

Registration

Ms Alice Joseph
 c/o Malaysian Medical Association
 4th Floor MMA House, 124 Jalan Pahang
 53000 Kuala Lumpur, Malaysia
 Tel: +03 4041375/40418972/40420617/4041370/40411743
 Fax: +03 40434444
 Email: mma@tm.net.my Website: www.mma.org.my/event

RM250 (Ringitt Malaysia) for Members of the Malaysian Medical Association, the Bar Council Malaysia, the Malaysian Dental Association

US\$300 for Overseas Registrants

Accommodation - Recommended Hotel

Grand Seasons Hotel
 Jalan Pahang
 53000 Kuala Lumpur, Malaysia
 Tel: +03 26978888
 Fax: +03 269213333

Superior Single @ RM139 (including 1 breakfast)
Superior Twin @ RM151 (including 2 breakfasts)
Junior Suite @ RM299 (including 2 breakfasts)
All per room per night including breakfast