THE AOG
Towards Perfect Practice

SUMMER 2000
JOURNAL

Volume 15 Issue 2

AOG GOLF DAY 2000

Foxhill Golf and Country Club 6th October 2000

GURKHA'S & GUTTA PERCHA - DENTISTRY IN THE UKRAINE
AESTHETIC IMPLANT RESTORATIONS PART 2 - E COMMERCE
THE CHARITY BALL 1999 - THE CHITRAKOOT PROJECT - INDIA 2000

The Dental Directory

DELIVERING THE FUTURE OF DENTISTRY

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Dear AOG Member,

It gives me great pleasure to write, to inform you that The Dental Directory will, from the **1st August 2000** be **dramatically increasing the discounts** offered to you, as an **AOG Member**.

- **A 10.0%** discount off Branded Products shown in The Dental Directory Catalogue
- **A 11.5%** discount on all orders sent via The Desktop Directory Computer Ordering System on Branded products.
- **A 12.5%** discount off our House Preferred UnoDent, Perfection Plus and Degussa products.
- **A 14.0%** discount on all orders sent via The Desktop Directory Computer Ordering System on House Preferred products.

The New AOG discount structure represents a potential discount increase of 6.0% on Branded Products and 3.5% on House Preferred products. The new discounts will apply regardless of order value or size and will be shown on your invoice.

The table below shows your actual percentage savings compared, to our competitors published prices on the 50 products featured in the leaflet and assumes the maximum AOG discounts, of 11.5% and 14.0% from The Dental Directory.

	More Expensive than Dental Directory	Branded Products incl. AOG Discount	House Preferred Products incl. AOG Discount
Henry Schein Procare	**9.8% more expensive**	**21.3% saving**	**23.8% saving**
Minerva	**7.0% more expensive**	**18.5% saving**	**21.0% saving**
Claudius Ash	**10.4% more expensive**	**21.9% saving**	**24.4% saving**
Wright Cottrell	**10.3% more expensive**	**21.8% saving**	**24.3% saving**

I trust that you'll agree the New AOG Discounts coupled with our low Published Prices represent substantial savings for every AOG Member, when you buy your Dental Materials, Sundries and Consumables from The Dental Directory.

The Dental Directory can also offer your practice our unique Product Audit service. This should save your practice between 5-7% on your annual materials spend, before your AOG discount is added. We also offer a minimum of two promotional flyers per month, offering the very best promotional prices on all major branded products.

The Dental Directory has had the privilege of being the Preferred Dental Dealer to The AOG since 1994. In that time, we have donated 1% of each members monthly spend to the AOG Committee to help further the Groups aims, objectives and ambitions. You may be interested to note that since 1994, The Dental Directory has given on your behalf over £90,000.00 to the Committee. The Dental Directory intends to continue to make these donations.

If you would like a copy of our new catalogue, or would like to discuss how a **Product Audit can save your practice up to 7% off your annual materials spend,** simply call free on 0800 585 586 and speak to us, a member of my Sales Team will be delighted to assist you.

Yours faithfully
Mike Volk

Sales & Marketing Manager

INVESTOR IN PEOPLE

THE JOURNAL OF
THE ANGLO-ASIAN
ODONTOLOGICAL GROUP (AOG)

A LETTER FROM THE PRESIDENT

Dear Colleagues and friends,
We live in exciting times. The dawn of the new century, the birth and precocious growth of the internet, the challenges and miracles of biotechnology, the list is endless it seems.

Just thinking about it and trying to keep up, after a while one begins to feel a bit weary. Having been a great aficionado of every new toy on the market from the Sinclair computer to the WAP phone, I now sometimes wish for the simple times.
When surfing meant standing on a board for a nanosecond before being dunked under a great huge wave in the sea.

There is now a swell in feeling for return to traditional values. The importance of duty, charity, fellowship and a striving towards perfect practice, all strong values that form the foundations of the strength of the AOG.

Our efforts to promote good practice our involvement in charities both at home and abroad, our efforts in doing good within our profession are only a part of what we do and stand for and make our society unique. A uniqueness that is reflected perhaps in the fact that we are arguably the largest dental society in the UK.

On a more personal level; the fellowship, the friendships and support that we offer to each other in what is often an insular profession is what makes the AOG so special. Never mind the more tangible practical benefits of which we have many.
These include the exclusive discount deal we have with the Dental directory one that is the best so I believe for any society. We now have an arrangement and collaboration with the Bank of Ireland. The deal with the Bank is, I am told, one of the most preferential for any professional group and which should result in great savings and opportunities for our members.
We have participated and worked with international organisations to arrange international conferences. What an excellent way to see the world and to contribute to the Dental profession and to be ambassadors for the UK in the world of Dentistry.

Our Incoming President is Air vice Marshall Ian MacIntyre who will take over from me at the end of this year. His contributions to the AOG and his involvement are proof that our membership is wide, and increasingly so, across the entire profession.

This is as it should be and it would be even better if membership was encouraged throughout the rest of the dental team to include hygienists, nurses and technicians.

This year so far has been a very busy one. The Conference in India was a great success and a welcome break from the monotony of February in the UK. We have had many seminars and meetings, which you will read about in the following pages. All thanks to the wonderful efforts and enthusiasm of our committee who are a joy to work with. We now have a web site WWW.AOG-UK.org . Please post your comments at the AOG forum on the website.

As the saying goes, all this would not be possible without the enthusiasm involvement and participation from the membership. So please do support our seminars and social events and do join in the fun.

I look forward to seeing you all at our future events and in the meanwhile may I take this opportunity to wish you and your families a lovely summer.

Jatin Desai BDS, FDSRCS (Eng.)

EDITOR "speak"

It gives me great pleasure to report that the AOG has gone from strength to strength.

The good work put in by our past president Saif and now Jatin has paid huge dividends. Following up from Malaysia last year, this year saw a very successful participation of our organisation in India. A full report is included for readers in this edition. For anyone who missed the opportunity to be there, well you missed a treat.

Our past president Ruby was honoured with an MBE and is also the current Vice Dean, Faculty of General Dental Practitioners (UK), Royal college of Surgeons, and is no doubt giving his full support to Raj Rayan who was elected Dean of the Faculty.

The AOG supported a very worthwhile project in Chitracoot under the guidance of Naresh Sharma. One of those rare instances where it can be said that an effort has truly enhanced the quality of life in an area not so fortunate and has made a real difference for the future. The work there continues and readers are urged to look into this project, as direct involvement, even in a small way, will be greatly appreciated.

This year has also seen the development of our own web site www.aog-uk.org. this promises to be a very interactive opportunity indeed for our members.

In this issue my hope is that I have brought to you a taste of what has transpired over the past year and other articles of interest. Your comments are always welcome. May I also take this opportunity to wish you the very best.

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AOG Charity Ball 1999

The AOG annual Charity Ball was held at the Cumberland Hotel, Marble Arch on November 20th 1999.

This, the last social event of the old Millennium, was a resounding success thanks to a wonderful ambience, glamour, good food, drink and music and excellent service from hotel and catering staff.

The evening began with a champagne reception and canapés in the Carlisle Suite of the hotel. Guests were welcomed by the AOG President Saif Najefi and his wife Amtulla, who presented the ladies with a rose en route to dinner.

Organisers of The Ball - Dinesh Jani, Saif Najefi & Pomi Datta with Rish Mehrotra & Abhay Soneji (Not in the picture).

President - elect - Jatin Desai saying Grace.

President Saif Najefi with guest of honour - prof. Nairn Wilson, Mr & Mrs Robin Wild, Mr & Mrs Ruby Austin, Mrs Najefi and Nasreen Najefi - waiting to be led to head table.

At the Dining table.

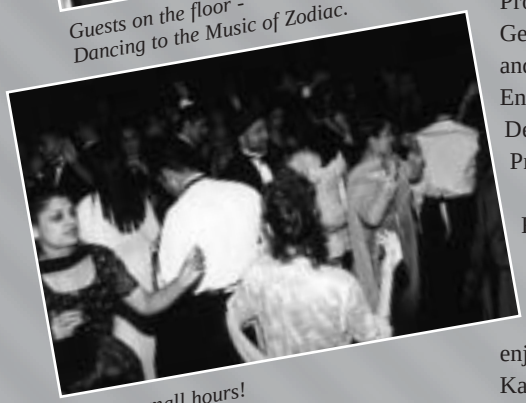
President Dr. Najefi then addressed the guests. He thanked the committee, the membership and wished the incoming President, Dr. Jatin Desai, the very best for 2000.

Professor Nairn Wilson (Guest of Honour) responded on behalf of the guests. Professor Wilson paid tribute to the work of the AOG and acknowledged the contribution of the AOG within the Dental Profession.

Following the formal proceedings guests danced the night away to the sound of the Zodiac.

Mrs Chande - One of the Raffle Prize Winners.

Guests on the floor -
Dancing to the Music of Zodiac.



Into the small hours!

At the Dining table.

The Guest of Honour for the evening was Professor Nairn Wilson, President of the General Dental Council. Other guests were Mr and Mrs Robin Wild, Chief Dental Officer for England and Wales, and Malcolm Pendlebury, Dean of the Faculty of General Dental Practitioners.

Following a lively reception, guests proceeded to the Grand Hall for dinner. The black and white décor contributed greatly to the glamour of the evening. One and all enjoyed a sumptuous Indian meal presented in Karahi Stands.

Saif Najefi - Addressing the Guests.

Special thanks go to all the sponsors for the evening:
The Dental Directory who sponsored the wine for the evening, and who have supported the AOG over the years.
Gandi Wines, sponsors of beer.
KaVo and Straumann for their raffle prize contributions.

a personal thankyou to all the AOG committee members who worked so hard to make this eventsuch a success, especially Dinesh Jani, Rishi Mehrotra, Saif Najefi and Abhaya Soneji.

The success of the evening was summed up by the difficulty in getting the die-hards of the AOG to leave the dance floor until 1.30am.

Pomi Datta, Social Secretary

Professor Nairn Wilson - addressing the Guests.

FINANCING IT EQUIPMENT

If your practice is considering purchasing IT equipment, you will know that there is a wide choice of systems available on the market. Whatever you choose, buying computer equipment is a major investment. John Baker, Area Manager for Schroder Finance Limited, discusses the benefits of using a specialist finance plan for the acquisition of IT equipment.

Background

There is still a widely held view that using leasing as a means of funding equipment is a relatively new concept. Some readers may be interested to know that equipment leasing in the UK has, in fact, been around for over 40 years. Schroders were one of the first companies to develop leasing and started in the photocopier market. Photocopiers are not dissimilar to computers in as much as they are highly technical pieces of equipment and are constantly being improved and modified. This factor alone provides a good reason for practices to use the benefits and flexibility of a leasing contract in order to keep up with modern technology and, thereby, remain competitive.

Much of today's modern dental equipment is computer driven so, as practices develop their range of treatment services, leasing is there to provide the perfect vehicle to meet patient demands and preserve capital budgets. Let's face it, there is little point in using hard earned capital to buy equipment which should be financed from the increased income generating by acquiring it! The trick is to minimise the effect of investment by utilising alternative and tax efficient methods of finance. As John Paul Getty once said: "Buy what appreciates; rent what depreciates!"

Leasing Options for IT

The most commonly offered finance for IT is lease rental whereby the finance company owns the equipment and leases it to the practice over the realistic life of the asset - commonly three years for an IT system. Leasing is the popular option because IT equipment generally does not keep a high monetary value over time with technology changing quickly. If you buy the computer equipment outright, your capital becomes tied up in a quickly depreciating asset. With leasing, the practice receives the benefits of ownership with full access to the equipment, without the burden of ownership. This is particularly important when a practice wants to upgrade its IT equipment.

As such, practices avoid the need to make a substantial capital outlay or pay a deposit and simply pay to use the equipment. Fixed rental payments are made monthly or quarterly. At the end of the lease period, practices have the option to continue to use the equipment at a nominal rental, upgrade the system as part of the lease agreement or end the lease. Lease rentals are agreed over the term of the agreement, so practitioners have the added peace of mind that inflation or changes in interest rates will not affect the payments. You can plan and budget in advance.

Choosing the finance route also means that existing credit lines, such as arrangements with your bank, remain intact. Your practice then has the additional flexibility to use its bank facilities in the future, if required.

An alternative finance arrangement to leasing is lease purchase. With this option, the IT equipment becomes the property of the practice at the end of the agreement.

Specialist IT Leasing Programmes

Leasing programmes with specialist finance providers who have dedicated IT finance services, such as Schroder Finance Limited, take the concept of flexibility further by encompassing upgrade facilities, hardware, software, insurance and service arrangements into lease agreements. Through this type of leasing programme, the customer can grow and change by upgrading the equipment as the practice develops. As customers do not own the equipment, they are able to 'change out' components or upgrade as they require.

With upgrade programmes, the rental payment can stay the same with equipment changes by extending the term of the lease. Alternatively, the practice may want to keep the same lease term and increase the rental when adding on to systems. The leasing programme is tailored to meet the needs of each individual practice. This type of rental is not unlike a TV and video rental where convenience and flexibility are key.

Computer Insurance

Specialist finance companies often can bundle computer insurance into a lease agreement. The cost of cover is included as part of the lease agreement and is spread over the term of the contract. Policies should cover loss, theft, fire and accidental damage. Schroder Finance's Complete Computer Coverage also has no excess charge if a claim is made.

With IT insurance, you can feel assured that your equipment is protected and that the lease payments will be covered in the case of illness, accident or death.

Choosing The Best Finance

When you choose finance to acquire your IT equipment, be sure that you are getting an individually tailored package, combined with a fast, efficient service at a sensible price.

Perhaps uppermost in your mind when considering finance solutions is the track record of the leasing company. Look for a company that demonstrates an unwavering commitment to professional and ethical business practices. Working with a company of this calibre will undoubtedly help protect you from any undue risk.

One important factor in choosing a finance company is the knowledge that you are dealing with a reputable leasing company that is a member of the Finance and Leasing Association (FLA). Members of the FLA are obliged to abide by the FLA's Code of Practice and ensure that contracts are clear and unambiguous.

Furthermore, when you are assessing finance companies, ensure that the company you choose has a division specifically dedicated to your profession and has specialist knowledge of your industry. Additionally, you may want to ask whether you are dealing direct with the funder or via a broker. Dealing direct means that you are speaking with a known funder that you can identify and contact throughout the term of the agreement.

Once you have made the decision to lease IT equipment, speak to the finance company's representative who will be able to guide you to the solution most appropriate for your practice's needs. Your accountant can also give you guidance.

Long-term View

Taking a long-term view is crucial for practice growth and success. This planning includes thinking about how IT systems will develop in line with practice growth. Mapping budgets to progress is one of the most difficult tasks practices face - but investing with an eye to growth will ensure that practices are able to adapt to changing technology and patient demands. Finance is, of course, an integral part of this flexibility and can help to promote forward thinking within a practice.

Benefits of Finance

- Regular fixed payments
- Tax deductible rentals
- Intact bank credit lines for future use
- Add-on and upgrade options
- Opportunity to include insurance
- Flexible programmes with hardware, software and services

What's my age got to do with it?

Asks Russ Ladwa

"Middle-aged man gets mugged in Ealing Common", said the headline in my local rag recently. It was about someone aged 49…but hang on, I am forty-nine and I am most definitely not MIDDLE aged, I reacted instantly. Why is that we are never happy, whatever age we are!

When our geriatric patients complain of frequently chipping or discoloured teeth, we can't say its just because of their age; but tell them, it happens to all of us with time, and they find it easier to accept (er, swallow).

We are trained to record the chronological age but also to assess the biological age. Add to this, the age, they perceive themselves to be and an adjustment for the age they 'feel physically' and suddenly it all gets quite complicated. Henceforth, this is to be known as the Ladwa True Age Index; first published here.

Have you been to an old-student's reunion recently? How have your peers fared? Most doing well but some disillusioned, maybe even giving up? All I can say is that as I approach the twenty-fifth anniversary of my graduation, life is just beginning! And what about all those Dental School lecturers who look the same as when you left? I persistently ask them what pills they take but they loathe to share their secret of eternal youth!

At my age, I notice how young the VDP's are getting. Unbearable that they are so frighteningly clever too! However, in this very politically correct age, while we may have got familiar with racism or nationalism, there is no place for ageism.I am a fervent believer that the young are the future of the profession and the nation. Above all, I hope they remember this when my Zimmer frame is delivered!

I recently said to a very senior friend and colleague that I had acquired an interest in gardening. He advised me to be careful how I shared this with others, for it usually meant a loss of interest in sex. Oh! How I loathe gardening, it can keep 'till I am 80 or better still, I'll take up woodwork. (Anyway, how does this apply to partners? And what of golf?)

We all have incidents in our lives that we remember as cornerstones or turning points. When I was eighteen, having just got poor 'A' Levels and facing an uncertain future ('the career pathway' might as well have been a rainbow) I recall a conversation with a seven year old girl. When I got no response from her as to what she wanted to be when she was older, I turned the question to ask if she could guess what I was going to be when I grew up; at which she retorted, 'What do you mean, you are already grown up'. This was my first Guru in adult life. 'Welcome to the real world'.

Much time has flown. Middle age has arrived, 'fait accompli'. They say it is a bad age as there is nothing to look forward to. Well they are wrong. This really is the time to be in dentistry now with it's advances and challenges. There is no other profession that would have allowed me to be a member of the community without crossing the front door step. Apart from being paid for doing what I enjoy, where else would I have been able to dabble in writing, teaching and playing at politics?

Just because age is a three letter word, it doesn't mean I am obsessed with it. I am glad that scientific frontiers are being pushed to extend lifespan to 120 years or even 150. My jaundiced middle age view is that the challenge surely is to improve the quality of life rather than merely seek to extend it?…

India The Land of Many Surprises!

Planning a trip to India is always exciting. A bit like going home, where one can let the hair down relax and take in the foods, sounds and culture with relish. However a trip to India can be a double edged sword fraught with delayed flights missed connections and of course the age old fear of the Delhi belly or a hundred other special lurgies that await the eager traveller.

Hence it is with a very special excitement that one awaits a trip to India and in this event, was made all the more special as we were actually attending a dental conference that was partly sponsored by us at the AOG along with our colleagues at the BSGDS.

Upon arrival at New Delhi airport we were picked up by members of the executive committee of the Indian Dental Association and very efficiently whisked of to the hotel in an air-conditioned bus. The Intercontinental Hotel at New Delhi is a five star hotel of the highest standards with many restaurants shops and excellent facilities and before long we were well ensconced into very well appointed rooms some of us (not me I might add) in deluxe suites! And soon we were enjoying the delights of Delhi cuisine in the all day restaurant. This was to me the beginning of many surprises as things could not have been more efficiently managed and it was so very pleasant to be in the company of colleagues from the AOG and the BSGDS enjoying a drink in the bar that the evening without a single mishap to report!

The opening ceremony at Pragati Maidan (which really is a National exhibition centre a bit like the NEC at Birmingham) was quite spectacular with approximately 10 000 people in attendance in the presence of the Vice President of India and the President of the Indian Dental association Dr KG Nair. The President made a speech which was not only short and to the point but enjoyable to listen to.

Honourable mention was made of the AOG and of course our 'great leader' Raj Rayan who was really the brainchild and inspiration behind our visit there. Raj Rayan was made an honorary life member of the Indian Dental Association.

The next day at the conference facility the organisation was smooth as ever. A tremendous achievement I am sure as there were twelve lectures running simultaneously and lunch was a huge buffet with cuisine from India and all over the world a great source of sustenance for the hard work put in by the members of the AOG at the Table Clinics

We had ten table clinics wherein AOG members together with BSGDS members ran table demonstrations. The topics ranged from endodontics to occlusion. The attendance at the table demonstrations was unbelievable. The crowds of local dentists sometimes four deep, milling around the tables was something

Table Clinics were a great success.

Saif emphasis the finer points in occlusion.

TABLE CLINICS
29th Jan. to 30th Jan. 2000
9:00am to 5:00pm

Dr. Rash Patel	Dr. Mike Hodgson
Dr. Amanda Rogers	Dr. Samandha Pugh
Dr. Raj K. RajaRayan	Dr. saif Najefi
Dr. Manny Vassant	Dr. Rashmi Patel
Dr. Dipak Joshi	Dr. Pami Datta
Dr. Siva Nithanianandа	Dr. Naresh Sharma
Dr. Scott Aaron	Dr. Beejal Patel
Dr. Nurperi Mehmed	Dr. Talli Taylor
Dr. Hitesh Chandergra	Dr. Luca Savio
Dr. Simon Cox	Dr. Trevor Bigg
Dr. Frank McCrea	Dr. Charlie Scola
Dr. Abhay Soneji	Dr. Jagdip Soneji
Dr. Ajay Ruparel	Dr. Kishore Soneji
Dr. Arun Deep Lamba	

Dr Naresh Sharma & Dr Siva Nithanianandа.

From Left: Dr Abhay Soneji, Dr Kish Soneji & Dr Naresh Sharma

President Jatin Desai & Dr Veerabahu

to see. The hunger for knowledge, the profound gratitude of the local dentists made all the weariness of talking non-stop through the day melt away. Special mention must be made of the winning table clinic run by our amazing V.T contingent. Their endodontic table clinic was the star of the show and well done to the participants.

The Dental Directory was represented by Mike Volk from the Dental Directory who was his usual ebullient self and stood us all many a round in the bar that evening!

The Dental directory with whom the AOG works closely contributed to the AOG sponsored a formal dinner which was attended by all the luminaries at the conference including the President of the British Dental Association, the President of the Commonwealth Dental Association, the President of the Indian Dental association and many more. The ball was a great success owing to the excellent entertainment lined up along with the sumptuous banquet.

The Dental Directory did us proud and we were all a bit bleary eyed the next day.

The trade exhibition at the conference was most impressive with products and companies from all over the world attracted by the huge Indian market no doubt. There were some amazing offers available especially with the strength of the pound. And many of our members were carrying huge parcels back to the hotel that evening.

Delhi in February is a very charming city and at night times when all the monuments were lit up the romance and allure of the east was much in evidence. The weather was idyllic, with temperatures ranging from 16 to 25 centigrade. The sun shone continuously and just as we were beginning to get used to it, alas for some of us as it was time soon to return home. All of us wished we could stay longer.

Most however had booked to go on the tours that had been planned and they continued to smile as we left for the airport and back to the delights of February in the |UK.

All in all the conference was a huge success and we felt proud to be a part of it. The content was very informative and interesting with international speakers from the world over. The stay there was without mishap hugely enjoyable with much fellowship and enjoyment. A very great thanks goes to Rash Patel who worked so hard putting it all together and of course Raj Rayyan for his inspiration and example.

I would certainly recommend to our members not to miss out and take part in our future conference collaborations being planned now even as I write this report. As they say please watch this space!

Jatin Desai

SUBIR BANERJI & RUSS LADWA

SPEND AN EVENING WITH

RUBY AUSTIN

For someone with so many achievements, Ruby is a lesson in modesty. Born in Mombasa when Kenya was a British colony, he received an MBE last year and with his characteristic humility was quick to point out the virtues of many other of his colleagues, who in his opinion, had served our profession so admirably.

Married to Maureen, they have two sons neither of whom has followed in his footsteps. Ruby's dental training started in Bombay (now Mumbai) in India, completely unbeknown to his father and on the persuasion of some his friends. Would you believe that his initial plan was to study microbiology, UK dentistry has to thank this loyalty to his friends for its undoubted enhancement due to his presence within the profession. Faced with an initial hostile environment in the Britain of the 60's, he was catalysed by his belief in the Gandhian philosophy of turning adversity into triumph. He proudly admits to Gandhi and his mother being the two greatest influences in his life. Ruby regards all his achievements and positions in office as a process of gathering knowledge, a characteristic which he still cherishes. During a reception held in his honour for his MBE last year, it was apparent how he has influenced the professional and social life of both the young and the more experienced.

Due to his zeal, involvement with the AOG was a natural progression and he became president of the society in 1994. Not one for convergence, Ruby was also elected the Vice Dean for the Faculty of General Dental Practitioners 1999-2000 and is also President elect of the BSGDS and Board member of the DPB and the Dental Vocational Training Authority.

Always encouraging new graduates to lift standards he has benefited many past and present vocational trainees. Setting the standards for current and future vocational trainers has become his hallmark, being a Dental Advisor for the Vocational Trainning Scheme since 1993 has given him this oppurtunity. He fondly mentions the help and support he has, and continues to receive, from colleagues like David Madden, Raj Rayan and Manny Vasant, to name but a few. The stamina and relentlessness with which he has supported the General practitioner is now beginning to pay dividends, a pursuit which he admits was not an easy task.

His numerous anecdotes put into prospective the daunting task of complying with the ever increasing list of regulations and legislature that confront us all and encourages the hope that it is still possible to please both our patients and our administrators.

A firm proponent for continuing education, Ruby is a strong supporter of the proposed Continued Professional Development. His commitment towards his colleagues in general practice is emphasised by the fact that he would like adequate remuneration and recognition to also be instituted alongside the CPD. Throughout his career he has motivated several younger colleagues like Rash Patel and Martin Hussain, to name but a few, through the DGDP (now MFGDP) and MGDS framework with resultant peer recognition, and views CPD as an adjunct to the career pathway for all practitioners.

Quick to share his experiences he is however reluctant to give advice, "all advice" he comments, "is dangerous", "good advice" he adds, "is positively lethal !!". A born diplomat, he proposes instead to treat each encounter as a learning experience. When asked for advice Ruby comments on how he would deal with the situation himself and gently, indirectly and by using very positive words guides and encourages a route which he invariably knows from his own experiences to be the right one. Commenting on a colleague who had a very busy single handed practice and who found it difficult, indeed unnecessary to attend meetings, lost out on 4 years of seniority payments, he emphasises the importance of his phrase that "you have to circulate to accumulate and isolation invariably brings grief".

He has the rare ability to make younger colleagues feel an equal. To his many friends and admirers this is all too obvious and having met him this narrative no doubt, will embarrass him, but credit must be given where it is due. The profession has and continues to be enhanced by his involvement. After finding time in his busy schedule, he drove halfway across London to meet us to honour our request to talk to him about his background, at the end, a mark of his generous nature, he insisted on paying for the dinner.

Ruby sees himself very much as the 'back room boy', working behind the scenes for maximum effect. He is gradually finding more and more time to pursue his passion for golf. Once looking for Ruby, David Rule, Post Graduate Dental Dean, phoned his home to ask Maureen where he was, "Don't know" she replied, "but let me know as soon as you find out, I am also looking for him !!"

Capturing Electronic Commerce Opportunities

By Leena Sankla, CEO & President Web Enabled Business (WEB) Ltd (UK-Dentists.co.uk)

Welcome

Welcome to our new and regular section on e-business, over the next few issues of this journal we aim to brief our readers on some of the common questions about e-business.

In this issue we aim to cover the following:

- Introduction
- What is e-business?
- How much has e-business grown?
- Why should I care about e-business?
- Why has the Internet had such an impact on business?
- How does the Internet enable an e-business to improve efficiencies?
- How will the Internet and e-business help me expand into new markets?

Subsequent issues will cover:

- Is the Internet really ready to support mission-critical business operations?
- What's wrong with the traditional business model?
- Can e-business catalyze a major strategic shift for my business?
- How has e-business created other new business models?
- How do I transform my business into an e-business?
- What is the difference between e-commerce and e-business?
- What is the future?

What is the Internet?

In the same manner that mechanical sciences have evolved, electronic systems are also migrating to new and higher planes. It could be argued that mechanical sciences were initiated by the art of writing, followed by the advent of Guttenberg's printing press, and later by the industrial revolution. If parallels are drawn, the development of digital computers can compared to early writings, and the World-Wide Web is the electronic age's equivalent of Guttenberg's printing press.

However, the Internet is the tip of the iceberg; a facilitator, or precursor, for the emergence of new paradigms founded on sharing and collaboration of data and information.

What ever you read, one thing is for sure the Internet is hear to stay, its growing at an extremely rapid pace its vital that you embrace it.

"If YOU don't see the Internet as an opportunity, it will be a threat" - Prime Minister Tony Blair

What is e-business?

E-business describes the way companies are using Internet technologies to fundamentally change the way they do business. An e-business is any business that uses the Internet or Internet technologies to:

- Attract, retain, and cultivate life-time relationships with customers
- Streamline supply chain, manufacturing, and procurement systems to deliver the right products and services to customers in the shortest possible time
- Automate corporate business processes to reduce cost and improve efficiencies
- Capture, analyze, and share business intelligence about customers and company operations with employees, suppliers and partners in order to make better business decisions

How much has e-business grown?

Focusing purely on the UK, growth figures are: Valued at over 400 BILLION by 2003

- 12 million in UK have Internet access
- 7 million Internet shopping this Christmas
- UK will have 14 million users by end of 2000 source Fletcher Research, Dec 1999
- 127,676 orders were processed through Open Interactive from launch until Christmas.
- Digital TV will reach 47% in UK by 2003 source Open.... Press Release Jan 2000
- 40% of consumer e-commerce will be conducted using wireless devices by 2004. source Gartner Group, 1999

Why should I care about e-business?

Embracing the e-business model will help your company expand into new markets; defend itself effectively from new competitors in those markets in which you already compete; improve business process efficiencies; attract and retain customers; and exploit new e-business opportunities.

Why has the Internet had such an impact on business?

First, the Internet is the great leveler--even small- and medium-sized companies can now compete effectively with larger and more established players in the Internet space. The Internet also creates greater market efficiencies by allowing companies to "disintermediate"--remove the middlemen--and sell products and services directly to customers. The Internet has also made price comparisons much easier for consumers, and has enabled dynamic trade--now online communities of buyers and sellers can match the demand and supply for a product and set its price accordingly. As a result, traditional profit margins are facing severe pressure.

At the same time, however, while fueling the competitive pressure, the Internet also provides companies with the technological infrastructure they need to streamline their business processes. For instance, it allows companies to streamline traditional administrative business processes to self-service, resulting in lower cost and less overhead, and to better integrate its supply-chain partners to fulfill orders more efficiently.

How does the Internet enable an e-business to improve efficiencies?

In numerous ways across the board, but to cite one example: Cisco Systems, the world's largest supplier of network equipment, conducts over 73% of its business over the Internet today. The shift to the Internet has reduced the lead time required to fulfill orders from three weeks to three days. While total revenues have grown 500 percent, the number of employees required to service requests has grown by only one percent. The Internet have enabled Cisco Systems to radically improve business process efficiencies.

How will the Internet and e-business help me expand into new markets?

Because the Internet is a global communications infrastructure that eliminates geographical and national boundaries, every company--including yours--can now offer products and services to a global audience in a global marketplace. Another impact of the dissolution of these boundaries is in the market sectors themselves--traditional boundaries that have existed between markets have also eroded.

AESTHETIC IMPLANT RESTORATIONS - SURGICAL AND PROSTHETIC HARMONY

PART 2 Full Mouth Restoration

Ashok Sethi BDS, DGDP(UK), MGDS RCS(ENG)

Full Mouth Restoration Without Bone Grafts

Adequate volume of bone, both in terms of height and width is necessary and is assessed using CT Scans. Though there may be adequate bone for the support of implants it is quite common to find that a certain amount of resorption of crestal bone has taken place. This may result in teeth that are 3-5mm longer than a typical incisor length of 10-12mm. The correct occlusal vertical dimension needs to be established. Changes in the occlusal vertical dimension will affect the size, form, and position of the teeth. This will consequently affect the position of the implants and abutments that will support the restoration. This obviously has consequences for the patients ability to function. Finally this will have an effect on the patients face height as well as the facial profile.

Patients may often present with a failing dentition which supports failing restorations. These patients are strongly motivated and the treatment involves the transition of the patient from tooth supported restorations to implant supported restorations. Provisional restorations supported by any salvageable teeth will provide the patient with fixed teeth throughout the treatment period. This is of tremendous benefit to the patient because it allows them to function without any compromise.

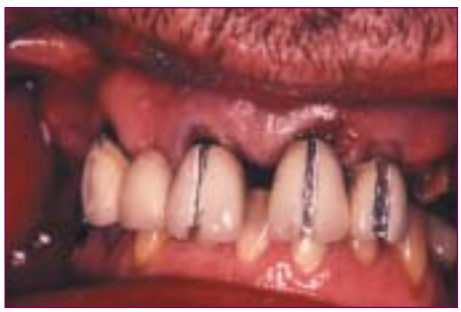
Primary Provisional Restoration

A metal acrylic restoration is fabricated. This is supported by those remaining teeth that can be retained predictably. Between three to four teeth are considered to be necessary. The metal acrylic provisional bridge enables the clinician and the patient to assess the aesthetics of the planned restoration. In addition it enables the clinician to assess the viability of any changes in the occlusal vertical dimension that may have been deemed necessary. This is often necessary as patients with failing dentition may have lost so many teeth that the original occlusal vertical dimension cannot be recorded.

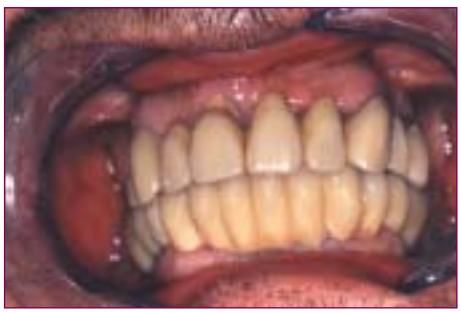
Once the occlusal vertical dimension has been verified by the provisional restoration a diagnostic template can be fabricated which will enable the implants to be positioned in the correct place and the abutments selected so that they lie within the prosthetic envelope established at correct occlusal vertical dimension.

Once the implants have been inserted, allowed to heal, and exposed a transitional restoration needs to be fabricated which replicates the newly established jaw relations.

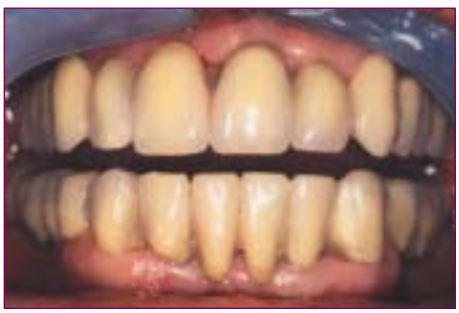
The definitive restoration is constructed by using conventional impressions to fabricate a stone cast. Cement retained restorations are the most predictable to construct and splinted units are preferred as this reduces lateral forces and provides cross arch splinting. The stages of



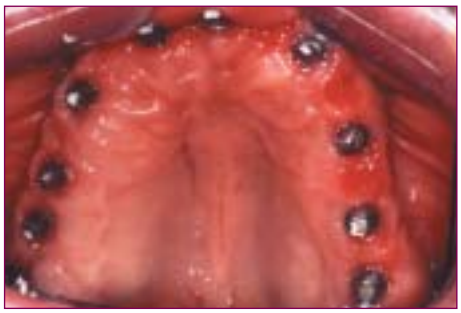
Preoperative view of failing restorations. The disastema created by the drifting upper incisors can be seen. The lack of posterior support has resulted in overclosure. The vertical dimension will need to be restored.



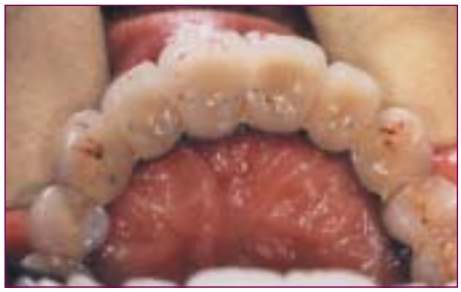
Provisional metal acrylic bridgework in place being supported by four teeth in the maxilla and four teeth in the mandible. Note that the correct vertical dimension has been established. It can now be verified over the treatment period.



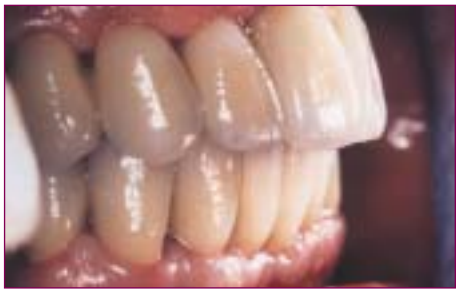
Following exposure of the implants a diagnostic waxing using denture teeth is carried out. This verifies the accurate transfer of information from the provisional restoration.



Occlusal view of the abutments showing that they are aligned and in tooth position. Conventional impressions are taken of these to produce cement retained bridgework.



Occlusal view of porcelain fused to metal bridgework showing that there are no occlusally approaching screws.



Labial View showing the aesthetic outcome and the maintenance of the jaw relations established at the diagnostic phase.

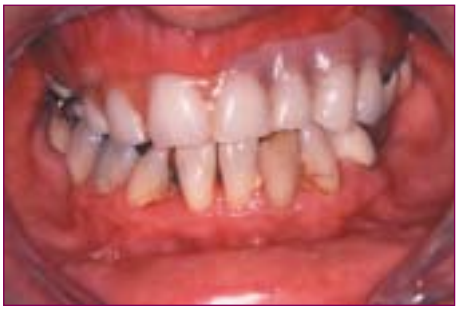
AESTHETIC IMPLANT RESTORATIONS - SURGICAL AND PROSTHETIC HARMONY

treatment require a diagnostic to confirm that the occlusal scheme established can accurately be transferred to the new abutments. Once this has been established metal work can be cast in sections and soldered, either prior to the application of porcelain of post ceramically.

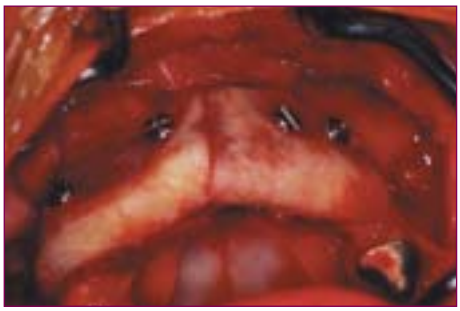
The use of cement retained restorations eliminates the need for labially or occlusally approaching screws. As a result better aesthetics and occlusal form can be achieved. In addition accurate but passively fitting restorations can be fabricated.

A further advantage of a splinted cement retained restoration is that in the case of the failure of an implant or natural tooth abutment the bridge can be removed, the implant or tooth removed and replaced with a new implant which can be connected back to the bridge once integration has taken place.

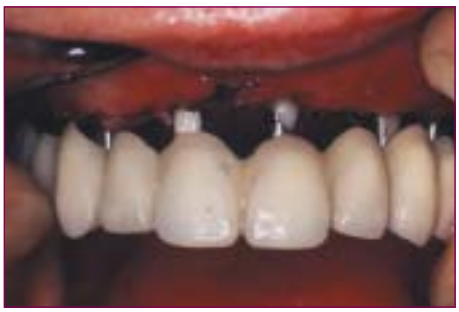
Aesthetically and functionally acceptable restorations can be produced predictably. Fixed restorations enable patients to retain function as well as their self confidence and self esteem.



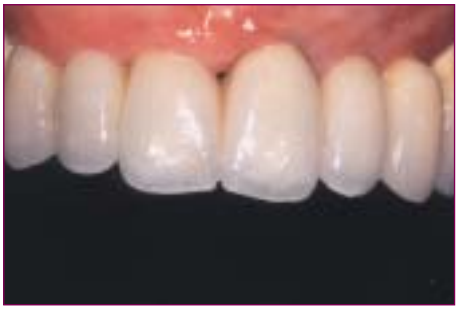
Labial view of a patient requiring treatment of the maxilla and mandible.



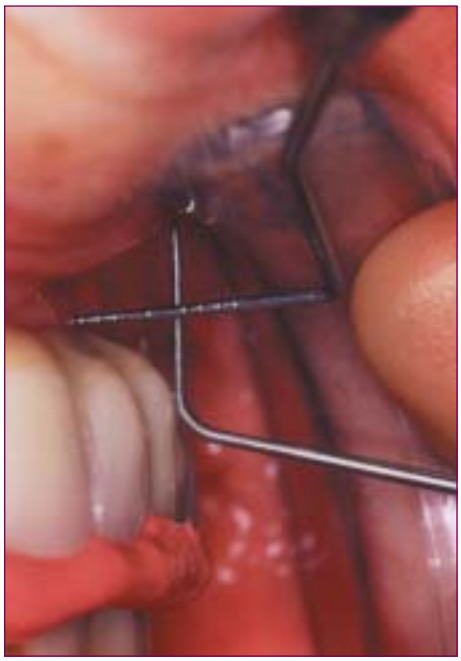
Cortical cancellous bone graft from the iliac crest in situ.



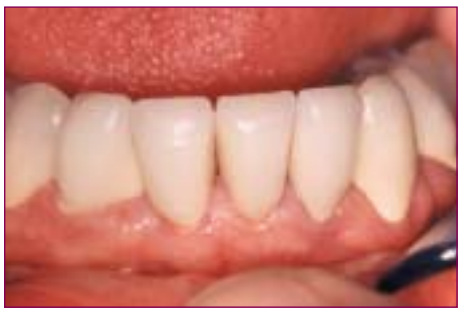
The implants exposed and the transitional bridge being fitted. Note the abutments are parallel to each other and in tooth position.



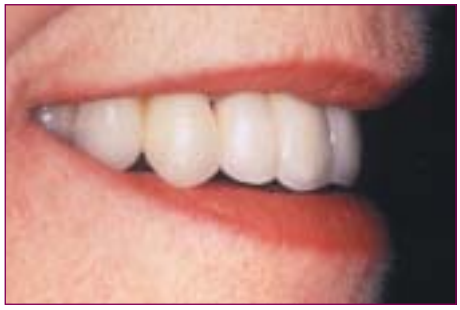
The upper arch restored with implant supported bridgework.



Provisional metal acrylic bridge without a flange showing the dimensions that need to be corrected. There is no bone support directly below the teeth.



The lower arch restored with anterior crowns and posterior implant supported bridgework.



Extraoral view of the patient smiling.

Full Mouth Restoration With Bone Grafts

Bone grafts become necessary when the available bone is insufficient in volume. Furthermore, there may be a discrepancy in the position of the tooth in relation to the intended position of the implant within the remaining bone. Bone grafts would therefore need to be placed to provide a foundation for the implants.

Cortico-cancellous block grafts are used and are shaped and secured to the residual alveolar ridge. An increase in the width or height can thus be achieved. Adequate bone is available from the iliac crest and is secured to the alveolar ridge using bone screws. The diagnostic template as well as the provisional restorations are used to confirm that the graft is positioned correctly. Typically a greater volume of bone will be attached to compensate for the resorption that will take place during the course of the treatment. The timing of the insertion of the implants is based on establishing that the graft has integrated but resorption has not progressed.

Implant Insertion

Implant insertion is carried out using the protocol previously described with the selection of abutments being carried out at first stage surgery.

Implant Exposure

Implants are allowed to integrate for six months prior to exposure and the attachment of the definitive abutments. Due to the atrophy of the soft tissues which is associated with hard tissue atrophy there is often inadequate attached keratinised tissue. Creating attached gingiva around the labial aspect of the implants requires attached keratinised tissue to be transferred from the palate. Transitional restorations are used to confirm that the correct vertical dimension has been achieved. Furthermore the transitional restoration will help create the gingival contours as well as the papillae as required.

AESTHETIC IMPLANT RESTORATIONS - SURGICAL AND PROSTHETIC HARMONY

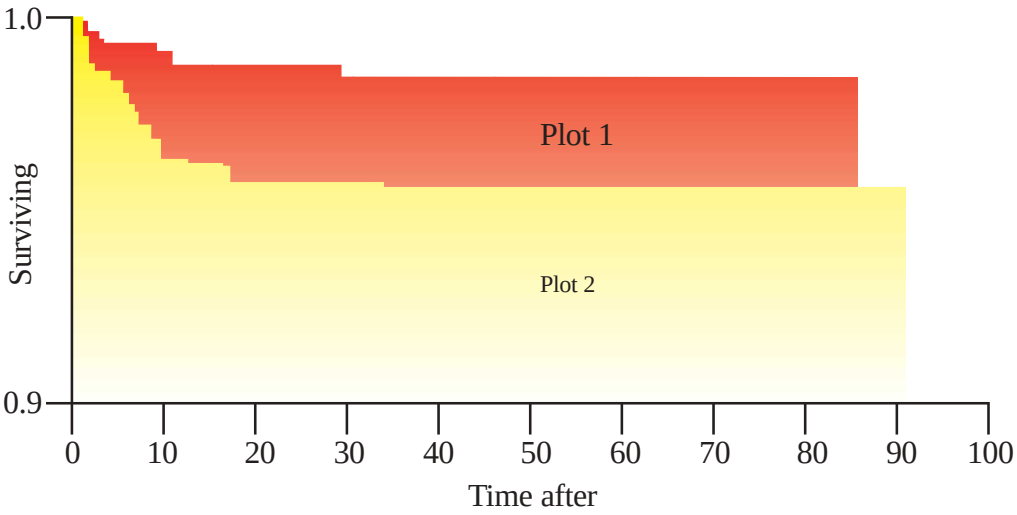
Restorative Phase

The restorative phase involves the construction of porcelain fused to metal fixed bridge with splinted units. This has previously been described and the numerous advantages of this technique enable excellent aesthetic and functional restorations to be constructed.

Summary

This paper illustrates the use of sound biological and biomechanical principles to achieve aesthetically and functionally acceptable restorations. The survival rate of implants has been observed and calculated using the Kaplan-Meier method. This can be seen in tables 2 and 3. When observing the survival of implants after placement 38 implants out of 2,101 failed. Observing the failure of implants after exposure and restoration it is noted that only 10 implants failed out of a total of 1,852. Consequently it is observed that the majority of the implants that failed did so because osseointegration was not achieved. Once the implants have integrated and are exposed and restored very few implants have been observed to fail. No failures have been observed after 30 months of function. The survival rate of implants when observed following placement is 97.7%. This includes all the patients that have been treated over this period, from 1991 to 1998. The survival rate of implants following exposure is observed to be 99.23%. Of these implants 1,413 were placed in the maxilla. Of these only 549(38.85%) required no augmentation. 371(26.26%) required ridge expansion. 314(22.22%) required sinus lifts. 156(11.04%) required autogenous onlay grafts and 23(1.63%) required guided bone regeneration.

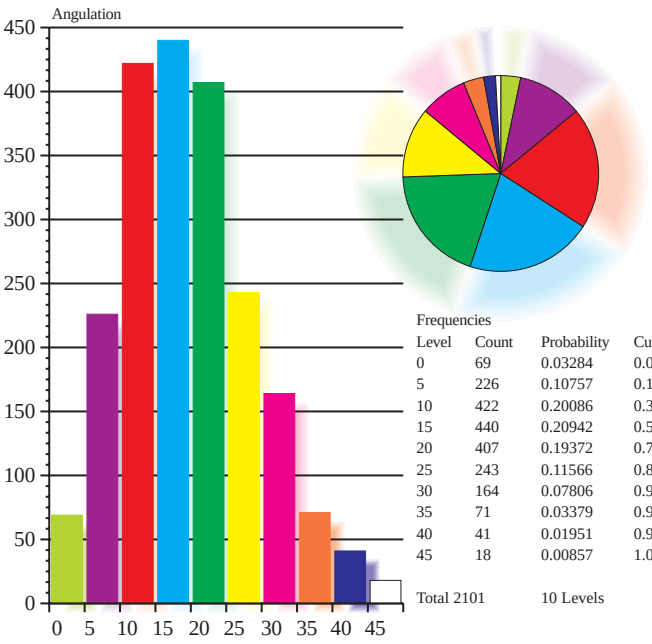
Implant dentistry is a predictable discipline that enables patients to be treated providing them with restorations that enhance self esteem and self confidence. Furthermore the restorations are therapeutic because they provide function stimulation for the jaws and the facial muscles thus restoring and maintaining the facial form.



Plot 1
Survival plot of 1852 implants observed from 0 to 83 months following exposure. 10 implant failed. 99.23% of the exposed implants have survived. There have been no failures after 30 months following exposure.

Plot 2
Survival plot of 2101 implants observed from 0 to 91 months following placement. 38 implant failed. 97.75% of the implants have survived. A larger proportion of the implants failed within 10 months of placement.

Distribution of angles. 2101 implants

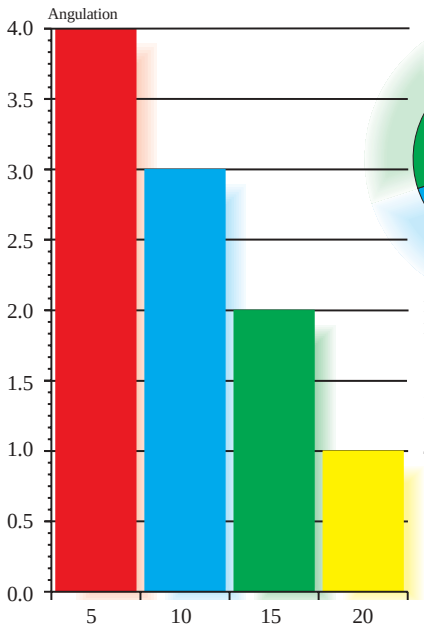


Frequencies

Level	Count	Probability	Cum Prob
0	69	0.03284	0.03284
5	226	0.10757	0.14041
10	422	0.20086	0.34127
15	440	0.20942	0.55069
20	407	0.19372	0.74441
25	243	0.11566	0.86007
30	164	0.07806	0.93812
35	71	0.03379	0.97192
40	41	0.01951	0.99143
45	18	0.00857	1.00000

Total 2101 10 Levels

Failed implants Distribution of angles



Frequencies

Level	Count	Probability	Cum Prob
10	4	0.10000	0.40000
15	3	0.30000	0.70000
20	2	0.20000	0.90000
25	1	0.10000	1.00000

Total 10 4 Levels

Indian Prime Minister Blesses:
The Chitrakoot Project

The Indian Prime Minister Shri Atal Bihari Vaypayee gave his blessing to the Chitrakoot Project at his official residence in New Delhi on Saturday the 22nd of April.

The Chitrakoot Project includes a large Hospital Site. A Dental Department has recently been set up there by Naresh Sharma who is the Dental Director. The whole of this Project has been financed by funds raised in the U.K. Two state of the art KaVo surgeries have already been fitted. One of these surgeries has been sponsored entirely by the A.O.G.

One of two identical surgeries.

The Prime Minister was due to visit and officially open the Dental Department on the 21st of April but had to cancel this engagement due to ill health. He was advised by his medical team not to travel to Chitrakoot where the temperature was around 47 c during the week. In fact the Prime Minister canceled all his official engagements including an address to Parliament the previous day.

The U.K./U.S. delegation (see photograph) was indeed honored to be invited to the Prime Minister's residence on the 22nd for afternoon tea. The Prime Minister said that India was a huge Country with huge problems but if we could replicate Chitrakoot type of holistic projects all over the Country we would go a long way to improving the life of the Ordinary Indian. The Prime Minister promised to officially visit Chitrakoot in November and pay a visit to the Dental Department.

About the Chitrakoot Project

The Chitrakoot Project was set up under the auspices of Deendayal Research Institute (DRI) three years ago. Deendayal Upadaya was a prominent politician in the 60's who said that India will not progress unless care is taken of its rural population. Nanaji Desmukh was also a prominent politician who worked alongside Deendayal Upadaya. After Deendayal Upadaya passed away Nanaji took over the task and set up Deendayal Research Institute at several sites throughout India. Nanaji gave up an active political career which according to many observers would have taken him to the top. He in fact decided to concentrate all his energies to improving the lot for the poor and hungry.

The outpatient department housing the dental department.

CHITRAKOOT is a little town about 120 KM from Allahabad on the border of Madaya Pradesh and Uttar Pradesh. This town has great significance for the Hindus as the Lord Ram spent 11 years here while in exile from his Kingdom. Hindus from all over India come to Chitrakoot for pilgrimage.

Nanaji decided to choose Chitrakoot as a site for one of D.R.I.'s Projects due to the pitiable conditions in which people lived. This is an extremely poor part of India where there are sparse health care provisions. In addition due to hostile environmental conditions the farmers struggle to make a living. Education is not available to the poor. There is no rural industry to employ the young. The young move to the big cities to add to the slums.

The D.R.I's Project incorporates 500 villages around Chitrakoot covering an area of 100 square miles.

The D.R.I's Project incorporates the following:-

EDUCATION:- Several schools have been set up in the area. Some of these schools are residential for tribal children who have no social structure and who's parents live in the forests. Education is provided to boys and girls of all sections of society without discrimination. D.R.I. believes that complementarity between schools, families and society is essential for the all round development of the New Generation.

Professor Monty Duggal (University of Leeds) with Nanaji in the dental chair.

HEALTH:- Life-long health is the main aim of D.R.I. They hope to achieve this through Ayurvedic, Yoga Sciences as well as conventional medicine. A huge Hospital (Argoyadham) has been set up at a beautiful site. This Hospital includes the Out-patient Department, Research Unit, In-patient Unit with 80 beds as well a Mother and Child Unit. This Unit has been funded entirely by the JRD Tata Foundation For Research In Ayurveda and Yoga Science.

THE DENTAL UNIT - (First Phase):- Two fully fitted surgeries have already been fitted

Panoramic view of the Hospital site.

in the Out-patient Department by KaVo-India. Amit Patel the Managing Director of KaVo-India has been most helpful in the design and fitting of these surgeries in this very remote part of India.

One of these surgeries will be manned by a full time local dentist and the other by visitors from the U.K. Two vocational trainees, Neema Naik and Louise Lilly carried out a D.M.F.T. Survey of 100 patients in 1998. This Survey surprisingly showed high D.M.F.T. scores for both adults and children. In addition we know that Oral Cancer is a big problem in India. Proper Education and early diagnosis could save many lives.

(Second Phase):- of the Dental Program will include a Mobile Dental Unit that will go around the villages and schools to provide Primary Dental Care. The B.D.H.F. are helping to raise funds for this Unit.

The Dental Director Naresh Sharma and wife Shashi with the Primeminister.

(Third Phase):- Will be the provision of maxillo-facial surgery at the Hospital. This is dependent on the construction of an operating theatre which is still two years away.

(Fourth Phase):- The provision of a simple prosthetic laboratory. This will be mainly for denture work.

In addition to the above Professor Monty Duggal, of Leeds is going to set up dental research projects at Chitrakoot, as well as send students for electives.

Reorientation of Agricultural Practices

Two Agricultural Colleges have been set up in the area. There are a large number of scientists carrying out research at these institutes and passing on the benefits to the local farmers. Some farmers have reported a 200% increase in their crop yield with help from D.R.I.

Rural Industrialisation

Cottage industries have been set up in the villages as well as a technical college at Chitrakoot to impart up-to-date technical and industrial training to young men and women of the villages.

Samaj Swasthya Shilpi Scheme

This is a scheme whereby two newly married graduate couples are invited to go and live in the villages for five years. Each couple is in charge of a cluster of five villages and help educate the villages. Basic hygiene and sanitation is taught. A school is also run for the children.

The U.K. delegation included Naresh Sharma and his family, Balbir Datta - Director D.R.I. U.K. Mr. Sukhdeve Sharma C.B.E., Chairman of Kirklees and Calderdale Health Authority and member of the European Commission and India Liaison Committee. Professor Monty Duggal - Professor of Paediatric Dentistry, Leeds Dental Institute.

Dr. Mike Galvin, Consultant Haemotologist at Pinderfields Hospital, Wakefield. Dr. Galvin

Naresh Sharma showing Nanaji the new dental set up.

is setting up a blood screening service at Chitrakoot. His wife Dr. Hazel Galvin is a Consultant Paediatrician at St. James Hospital, Leeds and is hoping to set up a paediatric service at Chitrakoot.

Dr. Radha Maheshwari came from Washington USA. He is a virologist at University of Washington and has done a lot of work on interferon and hopes to set up a microbiology laboratory to assess the efficiency of Ayarvedic medicements

Dr. Surman Kapoor with research background from the USA is the Director of Research at Chitrakoot.

How can you help

1) Volunteer to spend at least two weeks at Chitrakoot working in the New Dental Units.

2) Donate Dental Materials and small instruments for the two surgeries at Chitrakoot.
3) Make a financial donation. Cheque to be made out to SEWA International.

In all cases please contact:
Naresh Sharma
Telephone: 01924 405085
Fax: 01924 410838
E.Mail: Hecdent19@aol.com

aProfile of our current President

Dr. Jatin Desai

All good things come to an end, as has my term as the President of the AOG. A memorable year it was, with challenges, excitement and successes in many endeavours the committee undertook.

At the AGM held on 8th December 1999, I was delighted to hand over the reins of the AOG for the year 2000 to our incoming President Jatin Desai.

Jatin, normally a backbencher, is a dynamic character and is not just a pretty face. He has achieved a lot since coming to the UK, after obtaining his BDS from Mumbai, India in 1979. He sailed through the statutory exams in 1980, and proceeded to complete his fellowship (FDSRCS Eng. 1982) whilst working at Bristol in Oral and Maxillofacial unit. As if this was not enough, he successfully completed a two year part-time training course in orthodontics. (1986-87)

He is now a principle and owner of four surgery dental practices in Reading, Berks. The practice accepts referrals for minor oral surgery and implants. He is also a dental post-graduate tutor for West Berkshire, and a member of the LDC.

Above all, Jatin is a committed and long-standing member of the AOG. As a Seminar secretary in 1998, he had organised quite a few successful lectures and seminars. I have complete confidence in his ability to uphold the high standards which have always been associated with the AOG. I wish him and the incoming committee a successful and rewarding 2000.

Saifudin Najefi.

Dentistry In The Ukraine

From this...

The whole Clinic, as indeed all the others in the town were bare of all but the most basic of equipment and supplies. The air is rife with the stench of burning tooth as all of the handpieces work without water. This I am told is the norm in the Ukraine and indeed with all the other states of the former USSR. My interest in this trip to Chernigov, a town about 34 miles away from the Chernobyl nuclear disaster, began in April when a friend of mine George Mills, who runs the British Aid for Deprived Children, told me that a considerable amount of dentistry in the Ukraine was carried out without any local anaesthetic and that two was on children! This brought back visions of Ndola in Zambia where we did a similar camp two years ago and had people walking as far as 40 miles just to have extractions.

I flew out to Kiev with George, on 2nd August. After the two-hour car journey, we were in Chernigov and then introduced to the various heads of the medical and dental departments of the town. Although Chernigov has a population of 350,000, it serves a total of 1.5 million people in that district. The plan for the next week was to assess the dental needs of the children who were treated in the three clinics of the town and where possible to also treat some of them myself. Luckily, George had transported 10,000 cartridges of local anaesthetic and 5,000 needles in preparation for this trip, as neither of us knew what to expect.

The first day of work started with a frosty exchange of words (I think my interpreter only gave me a mellowed down version of what they were saying) over the use of LA. At this particular clinic, they may have had an allergic reaction to their LA in the past and their policy was that it was risks that that they were not prepared to take. Small wonder that the children came into the clinic screaming and fighting! After much persuasion, they accepted that perhaps the LA made in Western Europe was not the same as that of Russian origin and we had no trouble after that. As with all the clinics there, the equipment was the same. It was either Russian of Czech in origin, there was no water in the handpieces, the aspirator never worked (try doing surgical extractions without suctions!) and the spittoon was small bowl at the side that had to be regularly emptied out. Of the three clinics I worked in, there were a total of two bitewing (55 kV) X-Ray machines to serve this rather large patient base. There were no autoclaves, and sterilisation was either by electric hot air ovens or simply a pan of boiling water on a cooker.

> “Even the gloves are ‘sterilised’ and re-used and the choice of extraction forceps ridiculously limited.”

Patients are seen on a first come, first served basis. The choice of restorative materials is very sparse and amalgam is not used for fear of mercury toxicity. Indeed, radiographs are very infrequently done for fear of further radiation-induced damage in this post Chernobyl era where these things are viewed with a certain degree of scepticism. Root fillings were basically Zinc oxide paste spiralled into the root canals: fillings were either Russian silicates/glass ionomers or Czech produced paste-paste composites. Light cured composites were available in the private adult sector but never in the state run children’s clinics. I later found out that the wealthier parents paid ‘extra’ money to the clinics if they wanted Czech materials or a LA to be used on their children. The clinics would in turn use this money to make up the shortfall in consumables that the state did not provide. Even the gloves are ‘sterilised’ and re-used and the choice of extraction forceps ridiculously limited.

In view of the overwhelming odds against then, I found our colleagues there remarkably cheerful. Most had not been paid for six months and that to on a salary of £40 per month. They are desperate for Western knowledge and techniques, for equipment that works and for materials other than Eastern Europe in origin. They want to improve the plight of the children, but in a state, which has a mountain of other problems, children’s dentistry comes very low on the list of priorities.

Both George and I have purchased three complete surgeries from Peter Gardner who is the director of Dentaid, a charity responding to the needs of dentistry in the less-developed world. The surgeries will be transported to Chernigov in the next two months and will be used in clinics that house orphans or at the Revival Centre, which is a rehabilitation clinic of the disabled (mental, skeletal and psychological children following the Chernobyl disaster. A further trip is planned there in the coming months to ensure smooth functioning of the equipment and to take more consumable supplies.

Over the next twelve months, we have further plans to install three more surgeries in the main children’s clinic in Chernigov and for a further one surgery in Ndola, Zambia. Sadly, all these

...to this

...to this

To this.

projects have been entirely self-funded so far and put a severe restriction as to how much we can achieve without the help of our colleagues.

Yours sincerely

Jitesh Patel

...Continuing the series

I made a second trip to the Ukraine in November '99, with my friend George Mills, who runs the British Aid for Deprived Children and Tony Hibbert, a dental engineer with the charity Dentaid. The three dental units that we had purchased had cleared the Customs prior to our arrival in the Ukraine and our colleagues there had been informed that we only had a week with our engineer to install everything prior to our return back to England.

Upon our arrival on 7th November, we then found out that the next two days were Public holidays and that the chances of any work being done were rather remote. This basically left us with three working days to get everything installed and in working order! Rather than waste time, during the two holidays we spent time in transporting and assembling the equipment at the three different sites and also going to the local markets to search among an assortment of tubing, bolts, connectors and mouldings. This of course, is far easier said than done in this part of the world, where even getting the most basic of things can be a struggle.

> "They are desperate for Western knowledge and techniques, for equipment that works and..."

On the first day back from the holidays, we were let down by the electrician and plumber, both of whom had decided to go 'sick', (now where have I heard that before!). So we just decided to move onto another site in the hope that we might have better luck there. In the course of the next few days, it was not unusual to travel to all three sites in one day as they were all in various stages of installation. There were numerous occasions when we thought that the work would never be completed on time, as we could not co-ordinate the various tradesmen to come and do their jobs at the appropriate time. It seems some things are the same wherever you are.

> "It has been a slow battle to win the trust of the local dentists there, but the signs are very encouraging."

Through an enormous part by Tony, the three surgeries were finally installed on Friday afternoon whereupon I had to demonstrate the use of the equipment to the dentists that would be working at each of the sites. We knew that there would be a problem with the local authorities on the use of the intra-oral X-Ray machines (they have become excessively phobic on the use of X-Rays in the wake of the Chernobyl disaster) but as the equipment was already there, it was installed anyway. They also expressed concern with amalgam fillings but told me that if we supplied them in capsulated form, then they may consider using it.

The official opening ceremony of the three sites was held in January 2000 and to date they are in full working order. The surgeries are to cater for the needs of the children only and that too from the poorest of the families. Treatment will consist primarily of extractions, fillings and oral hygiene procedures. Any orthodontic work will have to be in liaison with the main Children's Polyclinic. There are plans to go back to the Ukraine this June or July (when the weather is more welcoming) and to install three, or possibly four other complete units in the main Children's Polyclinic of Chernigov. That will probably be sufficient units to cater for the majority of the children and we may consider a mobile clinic for those in the more remote areas around the town.

It has been a slow battle to win the trust of the local dentists there, but the signs are very encouraging. They too, like dentists the world over, fear the uncertainty of change but as long as we can support them, most of their problems can be overcome.

I have identified the range of consumable items that they are most in need of at all these clinics. These include gloves, needles and local anaesthetics, extraction forceps/surgical instruments, root filling cements/files/reamers, composites, capsulated amalgam, burs and general hand instruments like mirrors, probes, tweezers, etc. I am indeed grateful to all the well wishers that have donated these items and continue to do so. We endeavour to get it to Ukraine within three months upon receiving them, but I would like to stress that donations of larger items eg. Dental chairs, compressors, etc should be directed towards the charity Dentaid (Tel: 01938 811017).

The work has only just begun!

Yours faithfully

Jitesh Patel

A Short Career Commission in the Royal Navy

Surgeon Lieutenant Commander Anish Ashok

Having been born in India and brought up from an early age in England; with no military background whatsoever, joining the Armed Forces was initially a daunting move. I applied to join the Royal Navy shortly before I finished my MSc in paediatric dentistry at Kings College Dental school. Frustrated with hospital life and with several friends already serving in the forces, having what seemed to be a wonderful life I applied. In September 1993 I was invited to attend the Admiralty Interview Board at HMS SULTAN in the Portsmouth area. It involved 3 days of intelligence, mental, physical and leadership tests all under pressure to test whether we had the potential to be an officer in the Royal Navy.

On successful completion of the board I was offered a short career commission into the Royal Navy. I must say this time has flown.

The next stage was 8 weeks of formal military training at Britannia Royal Naval College. My time was spent learning about the Royal Navy its traditions, laws, discipline and leadership. Physical training also took up a large proportion of time including early morning runs, organised sports, fitness tests, and weekends on Dartmoor testing our leadership skills further. Boat handling and sailing was introduced.

We all completed a fire-fighting course; a damage control course- designed to introduce us into how to minimise damage to a ship, which has been hit. A Combat Casualty Care course was completed with the doctors to train us to manage and aid casualties in a combat environment. Nuclear, Bacterial and Chemical warfare training was also given. Finally I completed my Divisional Officers Course designed to assist me in the management and development of the military staff under my command.

I was then returned to the world of dentistry on my first appointment to HMS DRAKE in Plymouth. It was here that my first real experiences of living and working in the armed forces took place. Living in the Ward Room (Officers Mess) – a spectacular building accommodating all the officers who chose to live 'on board' from all the specialties in the Royal Navy including seamen officers, submariners, engineers etc. The naval base was large and friendly and was the home to our frigate and submarine squadrons.

I completed my Vocational training, which included 4 months in Hong Kong – an amazing experience. It was also during this year that I had my first taste of life at sea. I joined HMS Monmouth a type 23 Frigate on her crossing to Bermuda. Sadly a force 12 storm prevented much dentistry but a great experience none the less was had. Due to the awful weather I only managed 4 hours in Bermuda and sailed straight home on HMS Broadsword.

During my time at HMS Drake I also worked in the mobile clinic in the dockyard- taking dentistry right to the ships. I also assisted in the oral surgery lists at the now deceased Royal Naval Hospital Stonehouse.

In the 2 years spent at HMS Drake I completed my Sports divers qualification, played squash for the Plymouth region, represented the naval base and the dental branch at cricket and golf. I was fortunate enough to be selected to go on two large expeditions as medical and dental cover. The first to the French Pyrenees and the second to build a house for the Kenyan Wildlife Service in the heart of the African bush camping under canvas. This was followed by an ascent of Mount Kenya. A dream come true! It is opportunities like this that have made my role as a dental officer that much more fulfilling.

My next appointment was to HMS Raleigh- our initial entry establishment for non-officer candidates. Here I must admit the work was thankless; inspecting a 100 new recruits every Wednesday and then trying to treat them in-between all their other training before they left some 8 weeks later to their next establishments. However opportunities were always available and I grabbed them. I completed my Raleigh Expedition Leaders course allowing me to take new recruits onto the moors for their leadership exercises. I started to learn how to sail. I went as medical and dental cover to Nepal and walked the Annapurna circuit – a high altitude trek in the Himalayas. Treating the local villages on route. I also sailed on two more ships: HMS Edinburgh in the Gulf and HMS Marlborough in and around the firing ranges off Gibraltar. With these trips came the defence watches whilst patrolling off the Gulf coast but also the Embassy receptions and cocktail parties when alongside.

With my background in paediatric dentistry I was offered an appointment to be loaned to the British Army in Germany to run a clinic which not only treated the soldiers but also 1500 of their children. I was adopted by 1 Army Air Corps and had a fantastic year out in Germany. Working with the Army was different but they proved to be extremely charming and welcoming. The time spent there allowed me to catch up on my paediatric skills clinically and academically with some formal teaching to our vocational trainees. I also had 2 vocational trainees join me for their paedodontic module.

As ever my time with the Army gave me the opportunity to fly Lynx and Gazelle helicopters, drive a Challenger tank, travel all over mainland Europe and finally allowed me to go on an expedition to Peru as medical and dental cover providing care for many of the small nomadic tribes we came across in the mountains. I left Germany with many fond memories and friends.

On return to the UK I was offered another ship. This time HMS Cardiff off the coast of Naples. It was part of the Standard NATO force in the Mediterranean. Treating the ships company in between many of the war game exercises we took part in. From the ship I flew to Naples to treat our small British forces community working at NATO HQ in Naples. Yet another great experience!

In January of this year I was appointed to The Baird Health Centre; a military medical and dental centre facing the Houses of Parliament- an amazing view! I treat the Naval and RAF staff working in London which includes the most senior ranking officers in the armed forces.

So far I have had 5 of the most fulfilling years of my life with the Royal Navy and in my sixth year it continues to improve. I ski for the Royal Naval Dental Services at the Army Medical Services ski championships which for the last two years have been held in Canada. I have recently obtained my Day Skippers sailing qualification.

Wherever my career takes me I will always remember my time in the Armed Forces with only fond memories.

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From Malaysian Adventure in 1999 to Indiahhhhhhh - 2000

In April 1999, some 280 people traveled to Malaysia and over 60 UK Dentists, undertook lectured and table clinics at the joint British and Malaysian Dental Congress. It was quite a party as mentioned in the last AOG Journal.

Now, The Indian Dental Association along with the Commonwealth Dental Association have invited the BDA, FGDP, AOG and BSGDS to join their annual Conference. Some 8000 delegates were expected. The British Delegation were to run the table clinics and provide several speakers. The trade show was to be large and the scale exhilarating.

So off went the British contingent to India. Most of us departed on 27th January 2000 for Delhi. Some of the party went early to meet up with their family members, relatives and buddies and to shop early of course (who would not with the exchange rate at almost 70.000 rupees to a pound sterling).

A melange of the past and the present. Of its people and its antiquity. With attractions that span beautiful ancient architecture, marvelous monuments, romantic old style countryside. delightful villages, temples, mosques and churches, wildlife, rich flora and fauna, breathtaking mountains, panoramic landscapes, holiday resorts and varied cuisine.

India is home to spectacular array of cultures, customs and traditions. Presenting a modern visage of contemporary cities.

Indiaaaaaa - it has lots to discover and to share, and so much to learn and to appreciate. Indeed it's an experience in diversity. For you to cherish. Population - near 900 million. Culture - more than 1500 dialects, 18 officially recognised languages and several religions including Hindus, Muslims, Christians, Sikh, Buddhists, Jains and Parsis.
India, a supermarket of destinations is a source

due to snow at New York. Arrived at Delhi early hours of next morning - 28th Jan 2000.

THE CONGRESS AGENDA 27th - 30th JAN
INAUGURATION - 28th JAN 2000 4.00PM

The inauguration opened with a grand opening pageant in Hall 10 at Pragati Madan, New Delhi-India's International Exhibition and Conference Complex. All participants were invited to attend the opening Pageant and explore the complete and Register. The Chief Guest was His excellency Shri Kirshan Kant - Hon'ble Vice President of India. The Guest of Honor was Smt. Sheila Dixit - Hon'ble Chief Minister of Delhi. Dr. A.K. Walia - Hon'ble Minister of Health and Urban Development, Government of India.

Unfortunately, we were not allowed to take our cameras into the complex - for security reasons.

Band playing Outside the complex.

Within the complax - Inauguration.

Charging the batteries before dinner.

Dinner with entertainment.

Jatin handed over the cheque.

Audience participation.

Setting up of table clinics.

In front of table clinic area.

It was a shame that quite a lot of our colleagues and families were not able to join us because of commitments and school. Some of us did not mind that at all, did we 'lads'?
All alone in India - Freedom at last for 11 days. So instead of ll S's we had in Malaysia (Sun, Sea, Surf, Sand etc.) we were expected to have C's (Conference, Culture Shock, Classical Dances, Curries and more Curries etc.)

INDIA - THE TOURISTS' DELIGHT

India - a land steeped in Heritage

of fascination, mystery, and promise. Our troup was heading for Utter Pradesh-Delhi and Agra with its shimmering white jewel - The Taj Mahal. And Rajasthan - with its enduring romance and mystique.

EEEEnough of that. Now the real stuff.

THE ITINERARY:

27th January 2000
Departed Heathrow at approx 2.00pm instead of 8.45am. What a start. The plane was delayed

The ceremony started with Prayers and lighting of Diwaa's, followed by speeches and lastly presentations. Dr Brian Mouatt CBE was installed as the new president of the Commonwealth Dental Association.

Afterwards we were invited to a buffet dinner.

EVENING of 28th JAN - 8.30pm

Dr. Brian Mouatt CBE (Incoming president of CDA) and Dr. Victor Eastmond (Outgoing president of CDA) invited our party to attend a

Evening after hard days work. Mike Volk on Trisaw.

Humayun's Tomb (Pecurser of Taj Mahal).

formal dinner at the Intercontinential Hotel with Entertainment. It was a fantastic Evening.

The AOG President Dr. Jatin Desai handed over a cheque of XXXXXX Rupees to XXXXX for the Coimbatorre Library.

29TH - 30TH JANUARY 2000

On the 29th, early morning start for some of the party involved in setting up of table clinics. We were given space to set up our table clinics near the entrance to the Exhibition hall.

Over the two days, those manning the table clinics were kept so busy, that we had to take turns to disappear for Delhi Tours (organised for those not involved in any activity) and refreshments. The enthusiastic young and old Indian graduates and students, all smartly dressed were so hungry for knowledge, that it felt as if they were testing our knowledge to the limits. Unlike the Malaysian experience, the Indian experience will stay with us for a long time. Those involved with table clinics were surely made to earn their pennies worth.

Programme for accompanying persons

Old and New Delhi Tours
The attractions were - 1. India Gate
2. Parliament
3. Lal Qila (Red Fort)
4. Qutub Minar etc.

EVENING OF 29TH JANUARY 2000 - THE COMMONWEALTH EVENING

A gala evening organised at the Front Lawns - Hotel Ashoka. The delegates were accorded a royal welcome in the traditional style of the nobility of the Maharajas of yesteryears. The Elephants showered rose petals and cavalcade of folk dancers and musicians in their colourful costumes led the delegates to the venue. Apart from the entertainment, also thrown in was the opportunity to meander through food stalls, and taste the delicacies from the varied Indian Cuisine, and of course the Drrrrinks - All sorts. And orange juices for teatotallers like me. Probably the one. What an experience we had of Indian Hospitality - I leave it to the photos to tell the story.

THE MOGHUL TOUR 31st JAN - 5th FEB

31st JAN - TO AGRA - (203 kms)

Early morning coach drive (air-conditioned of course) from New Delhi to Agra. Enroute visited Akbar's Musoleum at Sikandra, which is a fusion of Hindu and Muslim architecture. Evening was at leisure. Welcome dinner at Mughal Sheraton Agra, and overnight stay.

1st FEB - AGRA

A half day visit to the TAJ MAHAL, built by the Moghul Emperor Shahjehan in 1630 for his Queen Mumtaz Mahal to enshrine her mortals remains. What a sight. There was an Aura about the place. No wonder, it is one of the wonders of the world. Everybody had a lovely time at the Taj. Later, we visited the Agra Fort containing the halls of private and public audience and other palaces. Evening at leisure.

2ND FEB - TO SARISKA - (40kms)

Enroute to Sariska - a Tiger reserve in the aravalli hills, we visited Fatehpur Sikri, built by Emperor Akbar in 1569 and abandoned after 15 years due to scarcity of water. Also visited Panch mahal and tomb of Salim Chishti.
Then to Bharatpur Bird Sanctuary - to see the birds - the real sort, (our eyes would wonder anywhere else - total concentration), pity non of us had binoculars, and enjoying the rickshaw ride at the same time.

3RD FEB - SARISKA THEN TO JAIPUR

Sariska National Park is Rajasthan's second tiger reserve. Early morning visit to the reserve in open jeeps with no guards - frightening. Yes we saw a deer, more deer, warthog, a jackass-oops sorry jackal, and more birds, but no TIGERS. Oh, Yes we saw the footprints near the side of the road. Exciting stuff, (I am beginning to sound like Raj). Oh well, no tigers this time, better luck next time!!!!!!

Something exciting and untoward did happen on the way to Jaipur. Exciting - we saw the birds - Yes birds, the human kind this time - ladies of leisure. The coaches stopped, and the way all men stood up to look, even Linford Christie would have been proud of the speed.

Untoward - one of the coaches broke down. So we all had to squeeze in one coach except a few adventurous colleagues. They hitched a ride on a back of a lorry. Manjul Vasant and his team had a nice ride, so he said.

4TH FEB JAIPUR - THE PINK CITY

Rajasthan - the desert state was once a conglomerate of princely kingdoms with feudal traditions. Today it is still visible in its varied ancient forts and palaces. Jaipur - the capital city was the stronghold of a clan of rulers whose hill forts and a series of palaces in the city are important attractions. Known as 'Pink-City' because of the colour of the stone used exclusively in the walled city.

Half-day excursions to AMBER FORT Accessible on Elephants backs as well to ascend the hill on which the fort is situated.

Visited the Jagmandir or the hall of victory glittering with mirrors. We had lunch at Hotel Holiday Inn, followed by city sightseeing tour visiting Maharaja's city palace and the Observatory. Drove past the HAWA Mahal or the palace of Winds and through the rose pink





Auro Fort.

View from Taj from Auro fort

Panch mahal.

tomb of Salim chrihti.

Sariska - Lodge.

residential and business areas of Jaipur.

EVENING OF THE 4TH FEB

We had an evening fairwell dinner and cocktails with classical Indian Dance performances at the Hotel.

5TH FEB - TO DELHI (258 Kms)

Overnight stay at the Intercontinential Hotel

6TH FEB - NEW DELHI TO LONDON

Early morning transfer to Delhi airport for the onward journey to London

ACKNOWLEDGEMENT:

Our Thanks To:

1. IDA and CDA for their kind invitation to participate in the Joint Conference
2. AOG and BSGDS for sponsoring the tour and event
3. Mr Raj K Raja Rayan for Masterminding the whole thing, assisted by Jeff Horton President of BSGDS, and Rash Patel.
4. Mike Hodgson for organising the table clincis. And as usual Dental Directory for sponsoring the table clinics.
5. Those colleagues involved with table clinics and lectures.
6. Brightsun Travel for organising the trip
7. Sita travel - for taking charge of our tours in India and providing us with good guides, who mingled with us very well.
8. To all in the party for behaving impeccably and looking after each other.

All in all, those who went to India, had a great time and enjoyed the tour and the Indian Hospitality very much, as we did in Malaysia

I sincerely apologise for any mistakes I may have made, or offended anyone, or have forgotten to mention for his/her good deeds during the tour.

Wart Hog.

HawaMahal.

Amber Fort.

At the observatory.

Maharaja's Palace.

Farewell Dinner.

Entertainment.

Dance.

NEW NEWS

DEBATE

A very successful statutory day held on the 13th of April 2000. Following the event, a debate "This house believes that corporate dentistry is a retrograde step for patient care" was hosted by Kish Soneji. Mahesh Patel spoke for the motion while Julian Perry, Managing Director of the Ora Dental Group, spoke against. The audience were presented with equally valid points of view from both speakers and at the final call the result was a close one with Mahesh ahead by 8 votes.

DENTAL LIBRARY

AOG supported Indian Dental Library opens in Coimbatore.

CHITRACOOT

AOG donates £5000.00 to the Chitracoot project in India.

THE NEW DEAN

Raj Rayan the new Dean of the Faculty of General Dental Practitioners, Royal College of Surgeons (UK).

Raj Rayan The New Dean

BANK OF IRELAND

offer exclusive deal to AOG members - watch out for details in the post.

Capt A.Z.M.M. Rahman

Gurkha's and Gutta Percha

I lay face down behind a mound, my objective now just ten metres beyond. I had crawled the last hundred metres through the wet marsh to this position. My combats were soaked. Knees grazed, and elbows raw from the rocks and streams I had scrambled through. My platoon was waiting safe in the woods from which I had emerged. I had been sent to take out the machine gun dugout. There was no crossing the marsh with this dugout and it's to Gurkha sentries in place.

I took a few moments to collect my thoughts, get a few breaths and complete my final checks. There was no movement from over the mound. Gurkha's being very vigilant and well-disciplined soldiers could wait for days without making a sound. I just hoped that they hadn't heard or seen me. I could vision them just waiting with weapons already zeroed for me to stick my head up.

Th safety on my SA80 was silently flicked off. I had no grenades left; all had been used up on our last attack. I took one last breath, bolted upright, sighted the Gurkha's and squeezed the trigger. No sound!!! Blasted thing had jammed!!! I re-cocked as I ran around their position yelling. I watched their rifle and machine gun sight me, they were shouting as I heard a shot followed by twenty- nine more. My SA80 had decided to work and I emptied the whole magazine as I screamed past the dugout on he uneven ground. I jumped over them and even noticed the whites of their teeth before catching my ankle and tumbling head over heals into a cold muddy ditch.

It was then I heard them laughing. I stood up and limped back to the dugout. Both Gurkha's were splitting their sides laughing at my poor attempt at a surprise attack. They'd seen me coming a mile off. The only reason I think they hadn't shot at me earlier was because they wanted to see me trip into the ditch they had dug for me. I looked down and realised what a sight I must be with my mud soaked combats (I hoped it was mud). Sparse foliage hanging off me and newly acquired limp. They were still laughing when the Colour Sergeant co-ordinating the training attack appeared yelling:

" What the h@# was that? I said surprise attack! Not bimble across the *$#@* field with your backside in the air, and what's the point of screaming like a girl when your %$#@# rifle doesn't work? Now sort yourself out before I rip off your #$&@ arms and beat you with the soggy ends, sir!*

It was at this point I realised that my skills as a dentist would far exceed my usefulness to the Army than my infantry ones. The Royal Military Academy Sandhurst, however, is something all Army Officers experience and is something all Army Officers remember, some with fonder memories than others. In truth, I enjoyed it; five weeks of intensive military training, lectures, late nights, exercises, and 6 am starts. The great irony being that as professionally qualified persons all doctors, dentists, vets, nurses, lawyers and padre's enter the Army as officers which makes us superior in rank to the staff. So, no matter how hard they yell and shout their exclamations always end with Sir, or Ma'am; it took some getting use to.

So what's life in the Military like as a Dentist? I joined as a Cadet at university in 1995, graduated in 1997, did my VDP year, got married, and am currently running my own centre in Germany. I have not experienced 'normal' NHS practice to which I can draw a direct comparison. However, my wife who is also a dentist, worked in the NHS for two years after graduation before joining me in Germany. From her as well as other University friends, I learnt what NHS dentistry must be like. A constant eye on the clock, the worry of what you'll earn from your next patient and how much you need to do to make an appointment worthwhile. A million patients in the waiting room and running an hour late.

We receive a salary, so the panic of lost income when patients don't show is less of a concern. However, as most patients are on the station normally, it just takes a phone call to get them in. The emphasis of Military dentistry is on the quality of work rather than sheer turnover. With soldiers deploying on military operations away from immediate dental facilities it is important to provide a high standard of care. So I take my time over my root fillings and cons to ensure work to the best quality is provided without worrying about how much money I'll lose if I spend some time on it.

Forces personnel are entitled to free treatment so the question of what the patient can and cannot afford becomes largely irrelevant. The Forces provide crowns, bridges, veneers, and specialists treatments for free if there is a justifiable clinical need. We also deal with a predominantly young and healthy population so I've not as yet had to pull out he BNF to check through a patient's four-page medical history. Also very few patients require complete dentures so if you, like me, dislike prosthetics then this is good news! Postgraduate training for dentists is also a priority in the military and is actively encouraged and funded. I am hoping to take my MFGDP this year.

Our actual military commitments are small during peacetime duties and routine management and treatment occupies the bulk of most Dental Officers time. However, in addition to this there may be other associated obligations such as Mess duties or club e.g. golf, riding, sailing commitments. Plus with being in Germany we have the rest of Europe on our doorstep: Paris, Prague, Berlin, Amsterdam, and Brussels all within a days drive. So if not attending a function, weekends can be used to burn off into a foreign country. Other postings include Brunei, Cyprus, Canada, Northern Ireland, the Falklands and of course the UK.

All three Services' dental care comes under the umbrella of the Defence Dental Agency which, to some extent, allows for dentists serving in different branches to serve in any location i.e. a Royal Force Dental Officer can work in an Army centre and vice versa. So all locations are potentially available to all three branches of the Forces. Furthermore, we also have a separate

war role during which we go on operational tours with the rest of the military. For this we have a mobile dental unit including chair, light, aspirator, compressor Xray machinery and instruments, all of which flat pack into a Land rover. The tours available at the moment are Bosnia and Kosovo and each last about six months. Well worthwhile for clinical and military experience, and of course if you are after medals.

In the Military we enjoy a completely different way of life with perks and privileges rivalled by no one. The Army has numerous adventure training facilities. Skiing, diving, parachuting, climbing and even golf can be experienced at much reduced prices. All it takes is a bit of legwork to find out what's going on and where.

You'll also meet some real characters in the Forces who, although they may travel around a lot, always pull together wherever they are and there's never a feeling of being away from home. One thing I haven't noticed is being made to feel different.

As an Asian I did have reservations about how the Forces would treat me and my special requirements (dietary and religious). The Forces have a well-established Equal Opportunities Policy. I've experienced no racism in the time I've served and am sure that even if I did it would be dealt with quite severely. As a Muslim I have had time off on Friday to attend Prayers and can even order Halal meat in the mess. Not all places have this facility yet but local arrangements can be made.

So what does it take to join? Well keen interest to travel, a craving for a challenge and adventure as well as being physically fit. If this sounds like you then what are you waiting for? See you soon.

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ART: Atraumatic Restorative Treatment

INTRODUCTION
Lima, is the capital city of Peru, a developing country on the west coast of South America. Access to dental care in the rural areas around the city is limited and the treatment available often lacks adequate resources and is unsophisticated. The WHO value for DMFT of twelve year olds in Peru is 7 compared to 1.4 in the UK. This high value reflects the poor standard of oral health of adolescents in this area and the need for dental treatment. The condition of the oral cavity often governs how people continue with their daily lives, certain aspects of which such as eating, laughing and socialising may be affected by poor oral health.

ART (atraumatic restorative treatment) is a recently reported field dentistry technique involving removal of carious debris using only hand instruments and the placement of a chemically cured glass ionomer cement restoration. This was devised by Dr. Joe Frencken (WHO) to provide treatment for patients for whom dental treatment is inaccessible.

An interest in ART and a desire to travel to Peru provided a good opportunity to gain a broader understanding of the clinical and social impact of dentistry whilst travelling to this part of the world.

AIMS:
- To gain a broader understanding of the clinical and social impact of dentistry in other areas of the world.
- To evaluate the ART technique from a clinical perspective
- To assess the acceptance of ART by patients and its impact on the quality of life on adolescents in Lima, Peru.

OBJECTIVES:
- Identify children needing Class 1 restorations
- Place restorations using ART technique
- Collect baseline data on site, placement and durability of restorations, and patient compliance.
- Collect baseline date on: a) impact of disability before treatment
  b) Pain experienced during treatment
- Review at one week and follow on data on survival of restoration and impact of disability after treatment.

PREPARATION:
Preparations for this elective started in October 1998 after reading about ART in a community dental journal given to us by Dr. Dunne, Professor Gelbier suggested we contact Joe Frenken Peruana, Lima, Peru) who agreed to help to set up this project and train ,us in ART. Before leaving for Peru, questionnaires had to be designed and instruments and materials required, several companies were contacted. Glass Ionomer Cement was provided by General Chemicals (Fuji IX) and Dentsply (Chemflex) both of whom also sent instruments. Claudius Ash supplied Gloves and masks. Problems with lighting and visibility were anticipated. Keeler kindly donated two sets of loupes with rechargeable headlamps which were to be given to the dental school on our return. Dave, conservation lab. technician, supplied cold sterilisation, sharpening stones and chip syringes.

METHOD:
- Dr. Ana Arana, with the help of her colleagues, selected children aged 13-16 years with cavities suitable for ART restorations. All the children were attending Nuestra Senora De Lourdes school 10km north of Lima.
- Our training involved a lecture on ART and its background, watching a video and a clinical demonstration.
- Before treatment was carried out written consent was obtained from a parent/guardian and medical histories were checked for any contradictions.
- Treatment was carried out in the school chemistry laboratory which was set up with two basic reclining chairs.
- Working in pairs, operator and assistant, treatment was carried out following the guidelines for ART restorations.

The ART group (Heena, Dipali, Fabrizio Terrazas, Meha, Clare and Dr. Arana in front of the Neustra Senora De Lourdes School, where the ART project was carried out.

The health centre at Los Olivos which provides basic medical and dental treatment.

Magnification loupes with headlamp donated by Keeler.

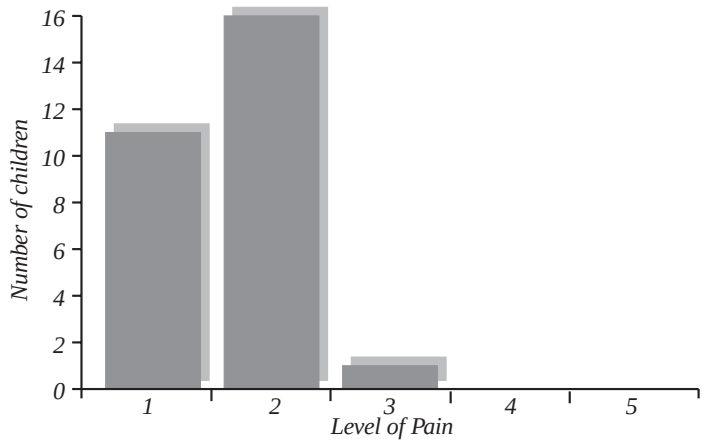
Working in pairs, operator and assistant, treatment was carried out following the guidlines for ART restorations.

Care Meha and Dipali carrying out treatment.

Fabrizio Terrazas asking the questions in the patient review questionnaire following treatment.

A graph to show the level of pain experienced by the children during treatment.

1= No Pain
5= Very Painful

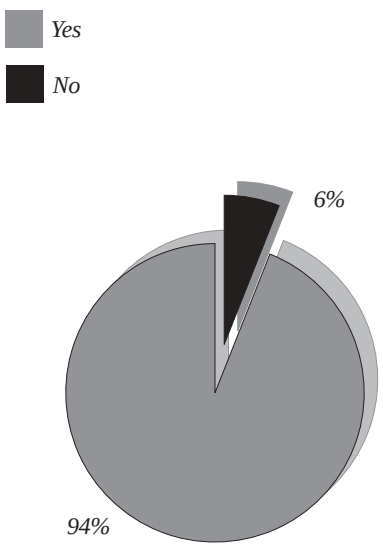


Equipment:
Instrument designed for ART were supplied by General Chemicals. Each set contained:
Mirror, Examination Probe, Tweezers, Excavator - 3 sizes, Enamel hatchets and chisels, Flat plastic & Carving instrument

Additional Equipment :
Safety Goggles, Gloves, Masks, Plastic spatulas, Chip syringes, Sharpening stone, Cotton wool rolls, Mixing slabs, Disposable syringes, Articulation paper, Cold sterilisation kit & Personal first aid kit

DISCUSSION
a) Student Review
In the study, chisels were required to access caries in 93% of the cavities prepared. This

A Pie chart to show the percentage of children who would have this treatment again.



indicated that cavities which seemed initially to be small, were in fact greater at the time of restoration. This is attributable to the fact that caries which perforates the enamel spreads along the amelodentinal junction. This is significant in ART, as sufficient removal of enamel may not be possible in order to gain visible access to the caries (SEE TABLE 1).

Confident removal of the caries was achieved in 94% of the cavities (31 from 32 cavities). Uncertainty in caries removal was due to difficulty in removing undermined enamel, and an inability to gain access to the caries. All the cavities were subsequently checked, and no caries remained before restoration (SEE TABLE 1).

During treatment 26% of the children asked the operator to stop as they were experiencing pain. Considering local anaesthetic was not used, and in some cases, a lot of force was required to chisel away enamel, this was considered to be a low proportion (SEE FIGURE 1).

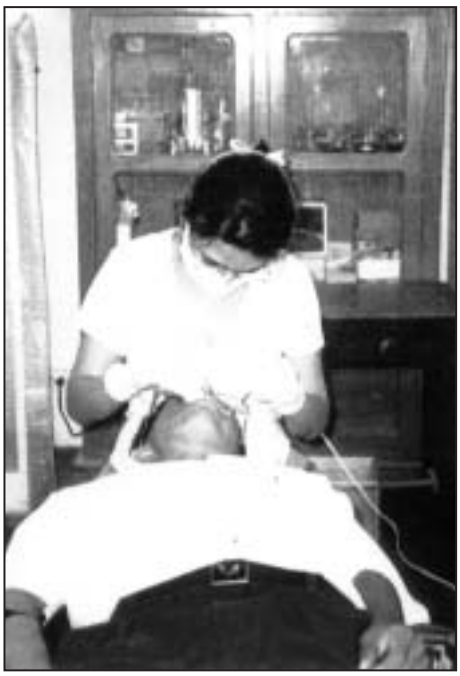
On reviewing the patients after one week, it was found that, in total, 6 of the 32 fillings placed, had failed. Four of these were CHEMFLEX restorations; two had been placed with the operator wearing loupes, and two without. Two of the fillings were FUJI IX, and again, one with the operator wearing loupes, and one without. This indicates that there is no significant difference in the success of restorations placed with or without loupes.

More than one half of one of the Fuji IX restorations was lost; this occurred as an air bubble was incorporated into the restoration during filling. This may be due to the fluid consistency of Fuji IX, and condensation of the material may not have been sufficient (SEE FIGURE 2).

It was noted that Chemflex was considerably harder to mix than Fuji IX, possibly due to the higher powder to liquid ratio. This will be investigated in the near future, by measuring the weight of one scoop of each material and each drop of liquid.

However, Chemflex was easier to place in to the cavity, and condensation was more effective than with Fuji IX. The setting times of both materials may have been decreased as temperatures in the room were considerably higher than normal room temperature.

The loupes were used in half of the restorations. Although the results do not show a significant difference in the failure of the restorations, it was felt that the loupes greatly improved visibility



Care Meha and Dipali carrying out treatment.

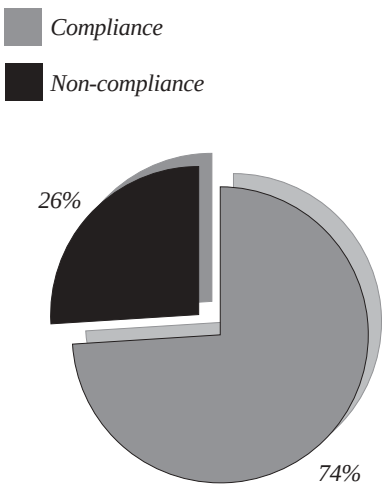
Checking cavities outside in the second week.

and posture (see photo 15).

b) Patient Questionnaire
Of the 32 children treated, 11 had no previous dental experience. Of the 21 children who had prior experiences, 38% had extractions, 31% had fillings, and 31% had dental check-ups. This suggests a low attendance pattern. There were more extractions than fillings, indicating that less emphasis is placed on prevention and continuing in this community (SEE FIGURE 3).

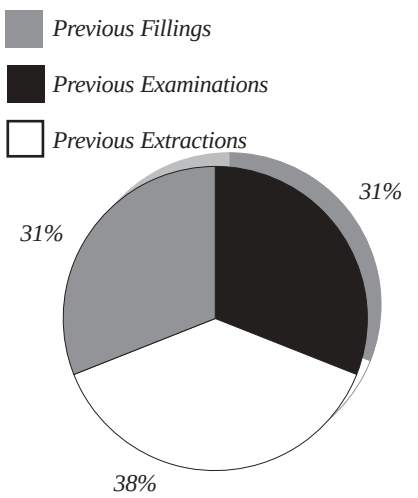
The patients were asked to score their pain experience during treatment, where 1 indicated no pain, and 5 indicated very severe pain. 12 reported a score of 1, 17 reported a score of 2,

A Pie chart to show the complience of the children treated during the study.



and 2 reported a score of 3. This shows that pain may have only been felt slightly, and, unless the cavities were deep, the pain may have been due

A Pie chart to show the previous dental experience of the children treated in the study.



to the pressure applied during enamel removal. It may have been beneficial to ask whether they were feeling pain or discomfort, and whether the pain was dental in origin (see figure 5).

On viewing the results of the changes in the "Quality of Life", it can be seen that 18 children experienced no change in quality of life, 11 experienced an improvement, and 1 experienced a deterioration. Therefore, the improvement in quality of life is significantly greater than deterioration; however, the majority of children experienced no changes at all. The latter may have been true, as posterior teeth would have no bearing on the patients' speaking and pronouncing, smiling, laughing or showing teeth without embarrassment. As the cavities were very small, the teeth were likely to be symptom free, and with no pulpal involvement. Eating and enjoying food and sleeping and relaxing were not likely to be affected (See Figure 4).

94% of the children said they would have the treatment again. This suggests that the patient acceptance of ART is high (SEE FIGURE 6).

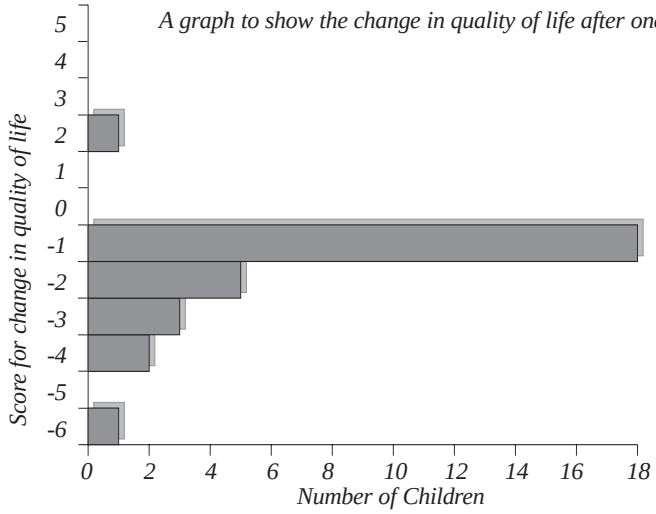
LIMITATIONS OF THE STUDY
On carrying out the study, we came across a number of limitations.

- No control group was used. This had two consequences. A significant comparison between ART and conventional restorative techniques could not be made. Secondly, there may have been a placebo effect, whereby the children gave desired responses.
- The sample selected was small. Therefore, the study may prove to be inaccurate as the statistical analysis may not be significant for such a small number.
- The cavities selected were small. This may have had less impact on the quality of life than a large cavity with deep caries.
- Limited experience in ART lengthened treatment times and caused difficulties in checking for caries in the in the small cavities, chiseling the enamel and handling of the glass ionomer.

CONCLUSION
The patient acceptance was high and there was an improvement in the quality of life for some patients. However, the technique was difficult to master and techniques sensitive treatment may be prone to failure. Short tern survival was good, but the true efficacy of the technique can only be measured following longitudinal evaluation of the restorations.

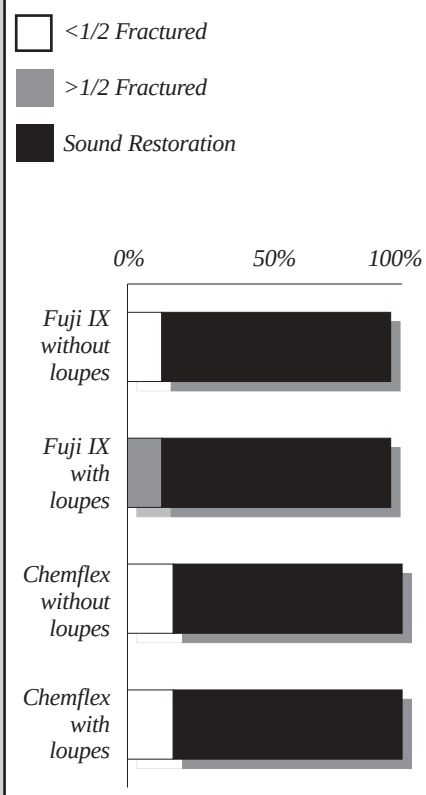
	Yes	No
Chisel Required to access caries	30	2
Confidence of caries removal	31	1

A graph to show the change in quality of life after one week.



A negative score indicates an improvement in the quality of life where -1 is a slight improvement and -6 is a greater improvement.

Graph to show the percentage of fractured and sound restorations after one week.



An Investigation into:

THE EFFECTS OF pH ON TOOTH ENAMEL

Enamel is the hardest tissue of the body that covers the crown of teeth in mammals.

The development of enamel is a complicated process and results in it chiefly consisting of apatite crystals containing calcium and phosphate when mature. 96-97% by weight of mature enamel is inorganic, only 0.4-0.8% is organic, while the remaining percentage consists of water.

The composition of enamel is essential knowledge when considering the effect of pH on the substance. The process by which pH will cause an effect on the enamel of teeth is known as erosion. Erosion is defined as a loss of tooth substance by a chemical process that does not involve known bacterial action.

During this investigation, the chemical process was brought about by the different pH levels.

While it is obvious that erosion in most cases is brought about through changes in pH, the aetiology of this disease is unknown in the majority of cases. Many suggestions have been put forward and tested. In 1946, McClure, Ruzicka and Zipkin and McClure suggested that erosion may be related to the citrate content of saliva. Their investigations were conducted on rats molar teeth and evidence for their case was found. However, when this was re-investigated in 1948 by Schulman and Robinson, they were unable to correlate the citrate content of the saliva with the occurrence of erosion of human teeth.

In 1963, Mannenberg discussed the correlation between tooth enamel erosion and the excessive consumption of acid fruit juices. This idea was followed up in a paper written by the French dentist, Maupome, in which he discussed the effect of acidic carbonated beverages on tooth erosion. Both men argued that these external factors are the initial causative factors in many cases of erosion.

In the April 1999 issue of "Dental Practice", Lawrence Aitken considered food regurgitation and rumination as a causative factor of erosion. He discussed the effects of both exogenous acids, i.e. acids introduced through diet and endogenous acids i.e. gastric juices from the stomach.

The aim of my experiment is to consider and investigate a few of the suggestions put forward by previous dentists on the causes of dental erosion. Primarily the investigation looked at the effect of pH solutions, however, further investigations were also done to see the effect of acidic carbonated beverages and antacid tablets on the tooth enamel.

Teeth were weighed and then placed in buffer solutions of pH 2, 3, 5, 7 and 8. Three teeth were immersed in each pH solution: an incisor, molar and deciduous tooth. The individual masses of the teeth were then recorded on ten occasions over two weeks. The same procedure was carried out for coke, diet coke, antacid, hydrochloric acid and acetic acid solutions.

Once statistical tests had been carried out, it was possible to see whether tooth enamel was in fact affected by pH. On the whole this was found and significant results were obtained. More erosion was caused by the acidic solutions than the alkaline solutions due to the percentage ratio of the inorganic to the organic constitution of enamel. However, it was shown that all solutions have an effect on tooth enamel including the results from the coke, diet coke and antacid solution.

These results were of significance when considered against the primary aims of the investigation. The positive results gained from the coke, diet coke and antacid solutions are of particular relevance to today's society. With an increased importance given to commercial products and an increased availability of goods these days, the intake of acidic carbonated drinks is on the increase. With "Coca Cola" being one of the world's largest companies, the consumption of their products is growing rapidly and coke remains the number one drink around the world.

The idea put forward by Aitken, referring food regurgitation was tested through the pH 3 and pH 5 solutions. Pepsin, a digestive enzyme, has an optimum pH value of 2. Therefore, the stomach, it's habitat, is modified by the presence of hydrochloric acid in order to accommodate it. In the case of people with bulimia, a slimming disease associated with induced vomiting, the teeth are constantly exposed to this hydrochloric acid in a diluted form. With the occurrence of bulimia now being more prevalent, the results gained at pH 3 and pH 5 levels were of utmost relevance.

Finally, the antacid tablets are an example of medication available over the counter at all chemists and most supermarkets. People frequently use them to relieve upset stomachs, indigestion and constipation. Their effect on the teeth had not previously been investigated. The observations made during this experiment provided some interesting results. Due to the permeability of enamel, the teeth placed in the pH 9 did not appear to erode away but rather gained weight over the two week period. While this was a limitation to the experiment, the results at pH 9 and the antacid solutions were statistically related and thus provided a good ground for comparison and the need for further investigation.

The biological significance is that, with increasing consumption of acidic carbonated beverages, the pH variation in the mouth can have detrimental effects on tooth enamel. With greater knowledge of tooth erosion, more emphasis can be placed on caring for our teeth. This paper has endeavoured to raise awareness within a society more inclined to drink acidic carbonated drinks, go on slimming diets and resort to medication for relief, about the side effects of these actions which are not often thought about.

Anjani Jani undertook this investigation as her 'A' level project. From October she will be studying dentistry at Guy's.

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A Textbook of Oral Pathology — *W.G.Schafner, M.K.Hine &B.M. Levy*

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Dental Practice — April 1999

The Probe — May 1999

Correspondence with:

The Coca Cola Company

British Soft Drinks Association.

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DO NOT MISS THIS INAUGURAL EVENT!

The Weekend Retreat at The Belfry
June 3rd & 4th 2000

Prof. Monty Duggal

Dr. Jatin Desai

On the Sat modern generation" and the speakers were Professor Monty Duggal Dr Jack Toumba and Dr Steven Fayle all of whom are from Leeds University.However the families that had accompanied the delegates were soon heading for the swimming pools and Jacuzzis and spouses arranging appointments for hydrotherapy and golf lessons!

Monty Duggal kicked off with his presentation on the delivery of highest standards in dental care for children. It wasn't long before it began to dawn on all present that this was not going to be any old course with a few mildly interesting lectures.

Monty Duggal enthralled us with his enthusiasm his firm conviction and zeal. Children the " poor unsuspecting buggers" who come to us for the relief of their pain, who come to see us so that we may administer tender care and attention are so often let down so often mistreated that we are almost singularly responsible for creating the large group of dental phobias that exist and will exist in the future.

Amongst the audience we had a contingent from the Armed forces led by no less than our President Elect Air Vice Marshall Ian MacIntyre. So it was most interesting to hear Monty go through the history of Paediatric dentistry and the influence that the Armed forces had in recognising the need for best dental care for the young as far back as 1840. The army had problems finding young men capable of tearing gunpowder sachets with sound teeth to load their muskets! By the end of the lecture which was electric in content and delivery I do not believe there was anyone there not convinced of the benefits of treating children with local anaesthetics pulpotomies where indicated with the use of stainless steel crowns.

Steven Fayle spoke next on behavioural management and again it was evident that the science had moved on. An excellent presentation which was exhaustive in its advice and procedures to disarm the most anxious child.

After a heavy lunch at the Atrium restaurant it was going to be heavy going to say the least. However Jack Toumba was the perfect antidote. He has had an amazing scientific back ground with several degrees to boot along with a PhD. His research into fluorides was very illuminating and his concept of the fluoride-releasing device was explained. It is such a shame that another potentially great British invention is to be exploited abroad possibly the USA. Monty and Steven then finished of with talks on the treatment of traumatic injuries in children. Many myths were dispelled and a very clear guide given as to how to treat injuries. " Stage of root development " still rings in my ears! Monty repeatedly stressed that the treatment depended so much on the stage of root development, as the aims of treatment were to ensure apexogenesis.

The session ended with questions and no one wanted to leave though we were running almost an hour late. A day where much was learnt and where we all took away something that we would all almost certainly implement at our practices on the Monday.

After that was of course time for liquid nourishment much needed and well imbibed by one and all! The dinner was marked by a very humorous speech by our illustrious ex President Ruby Austin MBE. He had us all in stitches and soon everyone was rendering forth with theirs favourite jokes! The party moved on to the nightclub at the Belfry and I gather the proceedings there did not end till the wee ours of the morning! I shall say no more as my lips are sealed!

Sunday brought with it a fresh bright morning. Perfect Golfing weather! Thirty-six players gathered to tee off on the majestic Brabazon course. The world famous championship course which is of course the Ryder Cup venue next year. What a treat especially as the course was in immaculate condition after the B&H International. The weather held and though the rounds of golf were mostly far from perfect and much water was encountered in the form of water hazards the day was a perfect day for golf.

At the presentation lunch our Captain of Golf Ajay Ruparel who tied with Dev Madden with 34 points won on countback. A fitting exciting end to a weekend that was most enjoyable illuminating and where old friends met up and new friendships were forged.

Saving Lives

R RajaRayan OBE

My mother complained that she thought she had a swelling on her palate. It was pain free. She was told to 'see her son who does good root fillings'. The complaint was left to lapse – for a very long time. Some many months later she mentioned it to me whilst we had dinner in a restaurant. I took a peek and had her booked into see me the following morning. I saw her and referred her that afternoon to a maxillofacial surgeon. Routine tests and biopsy undertaken that week proved it to be a mucoepidermoid carcinoma some 2 cm by one centimeter.

How were we to treat it? I took opinions from oncologists, maxillofacial surgeons, general practitioners, the internet and family.

She was a young sixty, former Secretary to a Minister in Government, loved dialogue, enjoyed food, thrived on company, entertained frequently and was currently coordinating a multicultural concert in London with artists from the UK, Australia, India and Ceylon. Facing life with a deformity was the last option. Balancing risks with quality of life was the issue. 'I have had a great life and I have no regrets' she said. 'But at least leave me with my smile'.

We found a surgeon with small hands and large skills. He diligently dissected away the lesion down to the palatal bone, cauterised the palatine nerves and left the lesion to heal under an acrylic plate.

Despite excluding cancers of the salivary glands and nasopharynx, about 3000 new cases of oral cancers present themselves in the United Kingdom every year. Of these, about 1600 patients will die. It has a high mortality and morbidity and the ratio of deaths to registrations is higher than that for invasive cancer of the uterine cervix, breast and malignant melanoma. New cases are about 45 per one million per year in England and twice that in Scotland.

One of the very first patient's to visit me at the first practice I bought in Wimbledon came cheerily in and said, 'Doc, can I have some Bonjela?'. He said he had an ulcer under his denture and the previous practitioner had supplied him with a free sample. I took one look at his lesion, rang Queen Mary's Roehampton, arranged for him to be seen that afternoon and paid for the cab that took him in. His wife came by some several months later to thank me, but to also inform me that his funeral was just over.

The raison detre of dentistry is no longer the mere relief of pain, but the saving of a life.
The poor survival rate is due partly to the late presentation of cases, with some 60% presenting with lesions over 2cm in diameter. The main source of screening is the general dental practitioner and studies have not been encouraging about their ability to detect oral cancers early.

Hence not recording soft tissue screening is not negotiable. On average, the five year survival rate is anticipated to rise from the current 40% to 80 % when the oral cancer is detected early.

About 95% of all oral cancers present as squamous cell carcinomas.

The general site distributions are:
Tongue 28.8%; Oropharynx 14.9%; Floor of mouth 13.4%; Lip 11.3%; Gum 5.3%; Ill defined sites 7.8%; Unspecified 18.4%.

Some potentially malignant lesions are:
Leukoplakia, Erythroplakia, Chronic iron deficiency anaemia, Lichen planus, Submucous fibrosis, Lupus erythematosus, Actinic keratosis and Tertiary syphillis.

Cancer may present in the mouth as:
- Ulcer, wound or tooth socket which does not heal
- Induration of any mucosal lesion
- Tooth mobility without apparent cause
- White/red patches
- Pain/parasthesia with no apparent cause
- Fixation of mucosa to underlying tissue with loss of mobility
- Fungation/growth to produce elevated, cauliflower surface
- Dsyphagia without other reason

Those most at risk are:
- Men (2x that of women – but decreasing)
- Over forty years of age
- Smokers and other tobacco users
- Heavy alcohol drinkers
- Those who have had oral, lung or throat cancer before
- The immunocompromised
- Fair skinned people (lip cancer)
- Betel quid chewers
- Diet – high fat, low Vitamin A, iron deficiency
- Combination of the above

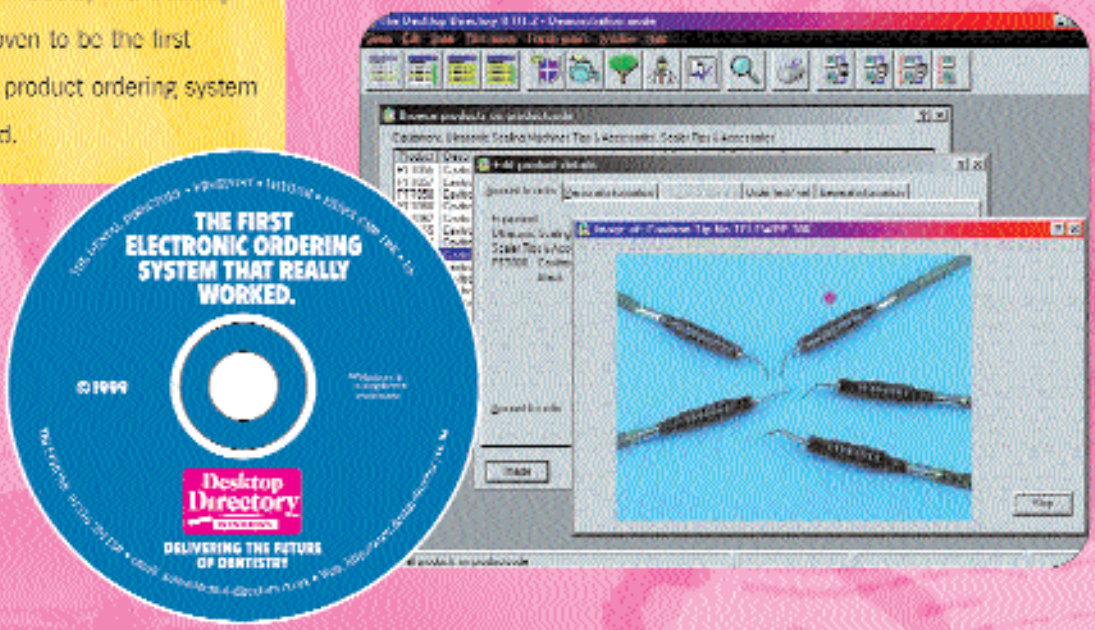
Screening should take at least 3 minutes, be systematic and cover lips, lower and upper labial sulci and mucosa, labial commissures, buccal mucosa, buccal sulci, alveolar ridges and gingiva, tongue, floor of mouth, hard and soft palate, facial tissues and submandibular and cervical lymph nodes.

This Faculty will subscribe to any standard which has the potential to help patients reduce their risk of oral cancer and to sign up to any protocol which will help detect cancer early. We are, after all, health care professionals first and dentists as part of that concept. Detecting oral cancer early saves lives.

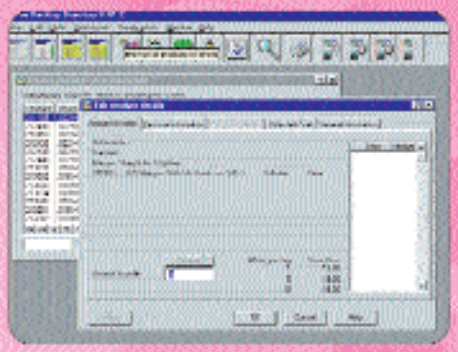
What of my mother? Despite the surgery, she carried on stoically with the concert. Everyone bought tickets, more as a tribute to her perseverance than the concert. The concert, nevertheless, was packed out and a huge success. She loved the fuss and continues to heal.

Should we have been so conservative in our approach? Only time will tell, but whenever she goes she will still have that beautiful smile on her face.

Since its launch in 1992, The Desktop Directory has proven to be the first electronic dental product ordering system that really worked.



DESKTOP DIRECTORY – ELECTRONIC ORDERING THAT WORKS



The Desktop Directory gives you access to thousands of products 24 hours a day, 365 days a year – and the system runs 'off line' so it won't tie up your valuable surgery phone lines.

The program offers the ultimate in ordering flexibility for all practices from the individual dentist to the large multi site group, and can be fully networked to give each practice member personal attention – including giving favoured products "pet" names for easy recognition and ordering.

With the new advanced CD ROM version for Windows 95™ you can call up instant pictures of the products you wish to order and, like the original DOS version, you can view the very latest products, promotions, multi buy offers, check on your own personal ordering history – and the program is completely secure and guarantees virus protection.

And to cap it all, ordering products through The Desktop Directory brings with it another outstanding benefit – an extra 1.5% discount.

What else would you expect from The Dental Directory?

Desktop Directory
WINDOWS

DELIVERING THE FUTURE OF DENTISTRY

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