COMMENT

Letters to the editor

Send your letters to the Editor, *British Dental Journal,* 64 Wimpole Street, London, W1G 8YS. Email bdj@bda.org.
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NHS dentistry

Historically weak

Sir, I wish to comment on Martin Kelleher's excellent article on 'State-sponsored terrorism'.[1]

I have no problem in agreeing with his assertions and interpretations of how our profession has got to be here. However, I'd like to add a few more perspectives to the debate. Firstly, it remains my belief that our predicament is a Civil Service-inspired initiative. This enables the constant eroding of our professional status despite the colour of the political parties in charge. I believe this began in the time of Thatcher government with Ken Clarke as the Minister of Health.

I do not believe the Civil Service hate us, but we have been historically weak in challenging governments which has given them an opportunity to practise their assaults on us and refine them for when they finally take on the medical doctors.

Over the last three decades, we have also seen the diminution of the role of the Chief Dental Officer in terms of his/her influence and the downgrading of their offices in both quality and location. One could even speculate on the former CDO's contribution to the position of our profession in relation to doctors and overall in society. After all, he was the mastermind of the 2006 contract that the Health Select Committee lambasted and despite years of trials of alternative schemes, it remains the only way we can deliver dentistry to the masses. We have witnessed the dreadful effects of this contract on children's oral health with record numbers submitting to GA clearances.

Finally, it is inconceivable to imagine Marks & Spencer allowing their buyers to be rewarded by the suppliers they negotiate with. Why do we have people aspiring to the top jobs in the BDA in an effort to seek the Queen's Honours? Have they all really done such a great job for the profession in negotiating with the government, that the same government advises the Queen to award them? I know this will provoke a few people but as long as it opens the minds of more then I am prepared for their backlash.

So what did I do to deal with the problems in UK dentistry? Simple, I walked away to another country where the governance is proportionate and the standing of the dentists is still high in the minds of the public they serve. The purpose of this missive is to support Martin in getting us to think why we are here and to inspire a few to help the profession back to the 'good old days'. After all, Einstein stated 'the definition of insanity is to do the same thing and expect different results'. I hope Martin's initiative helps move us to getting better results, especially for the younger members of our profession.

A. Gill, by email

1. Kelleher M. State sponsored dental terrorism. *Br Dent J* 2017; **223:** 759–764.

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In this together

Sir, the opinions expressed in the *BDJ* (Vol 223 No. 10) by A. Al Hassan,[1] a young graduate, Martin Kelleher,[2] an older graduate, and indeed yourself[3] were extremely interesting. I sympathised with the views of A. Al Hassan and fully appreciated his real concerns for dentistry and our younger colleagues practising in the climate of fear leading them to practise defensive dentistry. However, being of an 'age', I have lived and practised through the past analysed by Martin Kelleher and wholeheartedly agree with his analysis of the state we are in; we are all in this together.

The profession is demoralised and has been emasculated by successive 'regimes' of governments and regulatory organisations like the GDC. I have never heard the GDC make any comment about regulatory changes, especially when they are not in the interest of our patients. The GDC is an arm of the government and not independent.

The many crazy schemes under the 'item of service' were used to try to direct our clinical behaviour regardless of the benefit to our patients but purely to satisfy the Treasury.

'Item for service' certainly had its problems but it was so much better than the UDA system. It could have been improved to the benefit of patients and dentists. Barry Cockcroft, the CDO who oversaw the introduction of the present UDA system, said all the dentists were complaining about IOS, but as I pointed out to him, those in private practice who had the choice of whatever system they wanted basically used fee per item.

I despair at the damage UDAs have done to the dental health of the nation after great strides had been made in retaining dentitions through advances in operative techniques and prevention over many years. The damage also to the morale of the profession has been enormous.

Not everything that was done in the past was perfect but, I know from my own 'inadequate' practice, folk retained their teeth including some slightly sub-optimal root filled teeth for over the 30 plus years that I treated them for. We did molar root treatments, difficult extractions and anything we could to help patients and it generally worked. We did not have the fear of litigation from avaricious legal teams and patients were grateful for our efforts.

There is a dental world of 'swings and roundabouts', but in that playground world there is also a 'slide' and that is where I feel the dental health of our patients and the health of our dental colleagues has gone down.

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The GDC are supposed to protect patients but they have been totally negligent in allowing successive governments to 'abuse' them and then have blamed the dental profession when systems have failed. They are an organisation not fit for purpose and should at least have the complement of members like it used to have: more active dental practitioners voted on by the profession. We pay for it... 'no taxation without representation!!'

I am very grateful for both our colleagues for identifying what all of us really know, but have, unfortunately allowed to happen.

B. T. H. Devonald, Coleby

1. Al Hassan A. Defensive dentistry and the young dentist – this isn't what we signed up for. *Br Dent J* 2017; **223:** 757–758.
2. Kelleher M. State sponsored dental terrorism. *Br Dent J* 2017; **223:** 759–764.
3. Hancocks S. Listening and shouting. *Br Dent J* 2017; **223:** 743.

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Honours and awards

A call for action

Sir, honours and awards serve good purpose. In addition to providing a means to recognise excellence, commitment and exceptional service, honours and awards raise awareness, and demonstrate that outstanding contributions and commitment are valued. This call for action is to stimulate nominations for the 2018/19 round of the BDA's Honours and Awards.

Over and above President of the Association – the highest honour which can be bestowed on a member, the Association awards Honorary Membership, Fellowship, Life Membership, Distinguished Member status, the John Tomes Medal, entry to the Roll of Distinction, Certificates of Merit for services to the Association or dental profession and, as of 2017/2018, the Joy Harrild Award for Young Dentists. Details of these Honours and Awards – the oldest and most prestigious professional awards and honours in UK dentistry, may be found on the BDA website: https://www.bda.org/about-the-bda/association-honours-and-awards, together with the lists of past recipients.

As with any system for honours and awards, the standing and recognition of the system is dependent on the quality and inclusivity of the nominations. Historically, the BDA has been pleased to receive timely, high quality nominations for Association Honours and Awards, with the nominees coming from all sectors of dentistry, and from all parts of the UK. The Association's Honours and Awards Committee would, however, welcome more nominations, especially from Sections and Branches of the Association which only occasionally nominate a member, or have made no nominations in recent years. Guidance on how to go about making a nomination for an Association Honour or Award is provided on the BDA website, together with the nomination form. Senior officers of the Association are always pleased to discuss possible nominations of individuals considered to have 'gone the extra mile', serving the Association or the profession 'above and beyond all reasonable expectation'. Alternatively, please contact me: nairn.wilson@btinternet.com.

The deadline for the submission of nominations for the next round of Association Honours and Awards (2018/19) is 31 May 2018 (Joy Harrild Award, 30 April 2018).

Individuals must be in it (nominated) to win it (be recognised)! Individuals are unable to nominate themselves; so, it is down to others to take action. And the time to act is now.

Excellence, commitment and exceptional service should be recognised and celebrated.

N. Wilson, Chair,
BDA Honours and Awards Committee

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Oral health

A broader psychosocial approach

Sir, we are a team of researchers at Northumbria and Newcastle Universities, and read with great interest the article *Oral dryness and Sjögren's: an update* (*BDJ* 2017; **223**: 649-654). One of us (HC) is a dentist, familiar with dry mouth experienced by many patients. Therefore, we agree that although dry mouth is most commonly associated with medication use, it may also be an early presenting feature of primary Sjögren's syndrome (pSS). Furthermore, we agree that the oral health implications of a reduction in saliva volume are hugely significant, and a management approach aimed at addressing these is fundamental. Indeed, guidelines recently produced by the British Society for Rheumatology for the management of adults with pSS outline an approach to oral dryness based on 'conserve', 'replace', 'stimulate', which is entirely consistent with this.[1]

However, we would suggest that there is a place for an additional, broader psychosocial approach to oral dryness in terms of its impact on quality of life – specifically in relation to food and eating experience. As such, we would concur with Ní Ríordáin and Wiriyakijja's article (*BDJ* 2017; **223**: 713–718) acknowledging the psychosocial impact of oral mucosal conditions, and highlighting patient reported outcome measures, and the challenges of capturing accurate, comprehensive representations of issues identified by patients themselves as important. Recent research with survivors of head and neck cancer explored the eating difficulties faced by patients with structural and functional changes to the mouth and jaws, and radiotherapy-induced dry mouth.[2] This work found that the impact on eating extends well beyond the functional, pervading all aspects of life including sensory, cognitive, emotional, social and cultural domains. Patients who struggle with food become severely restricted in their daily activities and this has a detrimental effect on their quality of life.

These findings led us to develop a theoretical model, which we named 'The Altered Eating Framework'.[2] The framework conceptualises and maps the range of consequences of this altered relationship with food, and as such, may be applicable to many other conditions where normal eating is disrupted. We are investigating potential applications of this model. Currently, we are exploring eating difficulties experienced by people with oral dryness associated with pSS in order to address the paucity of research into non-pharmacological interventions for this condition identified by Hackett *et al.*'s systematic review.[3] We are developing a patient-led intervention aiming to address the impact of dry mouth on quality of life by applying the Altered Eating Framework to a mixed methods investigation of oral dryness and eating experience in people with pSS. We then aim to build a psychosocial intervention based on patient generated outcomes and perspectives.

H. Cartner, K. L. Hackett, D. L. Burges Watson, V. Deary, Newcastle upon Tyne

1. Price E, Rauz S, Sutcliffe N et al. BSR and BHPR Guideline for the Management of Adults with primary Sjögren's Syndrome. *Rheumatology* (Oxford) 2017; **56:** e24–e48.
2. Burges Watson D L, Lewis S, Bryant V *et al.* Altered eating: a definition and framework for assessment and intervention. 2017; in submission.
3. Hackett K L, Deane K H, Strassheim V *et al.* A systematic review of non-pharmacological interventions for primary Sjögren's syndrome. *Rheumatology* (Oxford) 2015; **11:** 2025–2032.

DOI: 10.1038/sj.bdj.2018.86