Member Newsletter

bsspd

BSSPD Annual Conference

15th/16th March 2018

Photograph: Dr. Alejandro Umanzor at Unidad de Prostodoncia Dental Pensando a future.

The British Society of Prosthodontics Newsletter, Volume 24, February 2018

President's Editorial

Phil Smith

I'm delighted to welcome you to the latest edition of the newsletter of the British Society of Prosthodontics. I am pleased to report that the Society has been active on several fronts over the past year.

One of our functions is the delivery of education and CPD opportunities in Prosthodontics and related disciplines. One way we fulfil this important commitment is through our annual series of Webinars. We are fortunate to have been able to assemble an impressive line-up of presenters who provided our members with invaluable learning updates in a wide range of contemporary Prosthodontic and related topics. The Webinars attract many participants but there are some members who have yet to experience them and I would encourage you all to sample some of them. You will need to sign up to join our live Webinars, but all members are able to access our impressive Webinar archive and obtain verified CPD for each one you complete so you might want to take a look at these. I encourage all participants, both regular and new, to spread the word to others, and perhaps attract some new members too!

Behind the scenes your Council Members have been working on your behalf to ensure the interests of the Society have been well looked after. Much effort has been devoted to identify and adopt a suitable platform to allow Council Discussions to take place online without the need for face to face meetings. This is gaining more importance as in recent times it has become difficult and increasingly expensive for Council to take time away from clinics. We have had a series of 'screen tests' and have found a platform that suits our needs and hopefully this will allow Council to become better connected when we need to work on your behalf.

BSSPD current and future Presidents have also been involved in initial discussions to explore how we can work closer with RD-UK and BSRD on areas of mutual benefit. It is envisaged that these will most likely relate to areas where 'political' statements are requested by other bodies, and around conference provision. You will be kept informed of any outcomes and rest assured there are no plans for BSSPD to be involved in a merger of the societies, we made it clear that we wish to maintain our autonomy and continue to follow our founding principles that support excellence in research, education and clinical prosthodontics.

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Undoubtedly the highlight of the year for me, and many members, is the Annual Scientific Conference. This year it is being held in Liverpool on March 15th and 16th in the magnificent setting of St Georges Hall, conveniently located close to Lime Street Station for those travelling by train. The conference theme is contemporary practice and is divided into two distinct days, and each day will, I think, offer delegates a thought provoking insight into patient management.

The first day is devoted to managing cleft lip and palate and we have been fortunate to assemble an array of speakers at the pinnacle of the various specialties involved in managing this most deserving of patient groups. The day will allow us to appreciate the background work that led to the current approach to managing CLP from birth into adulthood. It will showcase contemporary surgery, orthodontics, speech therapy and prosthodontics. Interspersed with this are poster presentations allowing members to inform conference delegates on contemporary research and clinical matters, and also enter for the Schottlander Poster Award should they wish.

The second day is designed to start with current research and clinical prosthodontics as oral presentations in contention for the prestigious Schottlander Oral Award. This will be followed by a truly impressive series of presentations by internationally recognised colleagues intended to stimulate interest and update delegates on aspects of contemporary endodontics, periodontics, tooth wear, and of course fixed and removable prosthodontics.

I really think that this year's conference will be stimulating and have something for everyone, and as well as enjoying the conference don't forget to take the opportunity to experience Liverpool, it's a vibrant city with lots to see. I hope to see as many of you there as possible.

Conference Programme

'Achieving Favourable Outcomes: Contemporary Practice'

Thursday 15th to Friday 16th March 2018, St George's Hall.

Please note that this programme may be subject to minor changes.

Thursday 15th March

08:30-09:30	Registration & coffee/trade show
09:30-09:45	Welcome and opening of conference by Sir Munir Pirmohammed
09:45-10:15	Overview CLP 'Why we are where we are. And where are we going?' by Bill Shaw
10:15-11:00	Surgery in CLP: Achieving favourable outcomes - challenges and solutions by Simon Van Eeden
11:00-11:30	Coffee and trade
11:30-12:15	Contemporary cleft orthodontics by Susana Dominguez-Gonzalez
12:15-13:00	Psychology in CLP patients by Zoe Edwards
13:00-14:30	Lunch, trade and Schottlander poster viewing
14:30-15:15	Fixed and removable prosthodontics in CLP by Andrew Barber
15:15-16:00	Speech appliances and speech therapy in CLP by Sandip Popat and Ginette Phippen
16:00-16:15	Tea and trade
16:15-16:45	Cases and Panel discussion
17:00-17:30	BSSPD AGM
19:00	Conference mixer drinks and finger buffet, St George's Hall Dress Code: Smart casual (email admin@bsspd.org if you wish to attend)

Friday 16th March

08:30-09:30	Registration and coffee/trade show
09:30-11:00	Contemporary prosthodontic research: Schottlander Oral Presentations
11:00-11:30	Coffee and trade.
11:30-12:30	Contemporary periodontics by Ian Needleman
12:30-13:30	Lunch and trade
13:30-14:15	Trouble shooting failed restorations by Peter Briggs
14:15-15:00	Contemporary endodontics by Mark Hunter
15:00-15:45	Contemporary removable prosthodontics by Craig Barclay
15:45-16:30	Contemporary toothwear management by Alex Milosevic
16:30	Prize announcements by Tony Preston
16:35	Handover to new president Phil Taylor
16:40	Close

Conference bookings can be made online via the BSSPD website: http://www.bsspd.org
Alternatively you can contact the sales administrator admin@bsspd.org

Prosthodontic Perspectives

Harold Preiskel

I am honoured by the BSSPD Gold Medal award of 2017 that has closed a personal circle of prosthodontic endeavors of more than half a century. The BSSPD was the first prosthodontic organisation I joined and the first I addressed more than 50 years ago.

I am fortunate that my prosthodontic journey has brought me in contact with some of the greatest names in the field throughout the world, but I made an unfortunate start. As a newly appointed lecturer in a hurry to reach my first BSSPD meeting in Cambridge I overtook the senior London professor with such a speed differential that his car was blown off the road by my slipstream-fortunately without damage. Later we were to remain friends for life. This was typical of the BSSPD where misdemeanors were quickly forgiven and one could disagree without being disagreeable. Heated discussions in the lecture hall were usually resolved over a pint (or two) of beer later on.

I have been lucky to liaise with marvelous colleagues in the academic, hospital and practice environments together with a wonderful team with which to work. So many have contributed. I can only offer a combined 'Thank You". Of course recognition is particularly sweet on home territory, while the achievements of former students provides paternal satisfaction. It is gratifying to travel to many countries in the knowledge there is a warm welcome there.

Working in numerous countries brought me in contact with outstanding individuals some of whom were unaware of similar work in progress elsewhere. An amazing London committee supported me in my endeavors to bring together prosthodontic leaders throughout the world to London to work with their UK counterparts. Members of the BSSPD joined the symposium in 1982 that was opened by Princess Margaret and proved an outstanding success. The Proceedings served a generation of post graduate students. The International College of Prosthodontists was born at this meeting and now represents more than 80 nations crossing both national and political borders. I am honoured to have served as its founding Chairman and later its first President. I am also happy to have assisted the

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foundation of the International Journal of Prosthodontics serving as its first co-editor and later Chairman of the Editorial Board. I've been fortunate to receive numerous awards but one of the more gratifying was to be appointed the first non-American President of the American Prosthodontic Society. In later years I was to receive their Golden Medallion award. This augmented the pleasure of having chaired distinguished UK organisations and profited from interaction with my colleagues here.

My interest in mandibular movements and related structures has been lifelong. It continues to this day. Returning from the American articulator wars with a newly minted degree I was surprised to find that chewing cycles, and masticatory movements received relatively scant attention. While my research in the field appears to have raised more questions than it answered, exposing unknown issues is an important part of investigation. The restoration of the partially dentate mouth led to my in interest in precision attachments that made possible improved overdentures and a plethora of solutions in prosthodontic fields. Several retention systems developed for roots work well on implants. Differential support from mucosa and periodontal ligament raised issues still pertinent today with implant supported overdentures.

For generations the nemesis of many a prosthodontist was the restoration of the resorbed edentulous mandible for a maladaptive patient. The advent of osseointegration added a new dimension to therapeutic possibilities. The edentulous mandible became eminently restorable with a fixed prosthesis as for the first time a life enhancing prosthodontic therapy became a possibility. Furthermore, an entire new range of answers became available for the partially dentate patient and those with maxillo-facial defects.

Osseointegration was originally surgically driven often producing irregularities of the occlusal plane, unusual tooth position, questionable aesthetics and unknown effects upon the supporting ridge of an opposing complete denture. Nevertheless few complained; most were overjoyed. The breakthrough had been made and the door opened to prosthodontic innovations.

This surgically driven approach produced greater complications in the maxillae where the pattern of bone resorbtion often resulted in implant placement well palatal to the optimal position for the artificial teeth. In these early days reduced lip support, excessively proclined artificial teeth or large gaps between prosthesis and mucosa were not uncommon. Nevertheless, the security and confidence felt by patients usually outweighed the drawbacks despite the occasional equine appearance.

Before long the versatility offered by the overdenture became apparent. The Brussels overdenture conference in 1989 concentrated on the number of supporting implants required, the possible need to connect them, together with retention units. However, the undercurrent was more important. No longer was it acceptable to place implants in convenient bony sites at odd angles then add on the teeth as an afterthought. At long last it was appreciated that the main purpose of the therapy was the replacement of missing teeth: the surgery should be planned with

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the desired prosthodontic result in mind. With this in mind the implant supported overdenture became a useful addition to the prosthodontic armamentarium.

The anatomical challenges of providing posterior occlusal support were met by pioneering surgical and prosthodontic protocols with the result that for a fit patient, there were few situations that defied implant placement. The realization that the area of interfacial osseogenisis did not have to match that of the lost periodontium led to a reduction in supporting implants placed for fixed prostheses. Site preparation including ridge augmentation, regenerative techniques, and sophisticated grafting approaches have resulted in better looking functional prostheses while digital protocols expedite and simplify planning and execution. The edentulous patient need not now be a dental cripple.

The implant is not a universal panacea. Peri-implant complications can and do occur. The science of Metrology, understanding surface chemistry together with an appreciation of implant/ host response are but a few aspects of ensuring predictable long term results. Digital technology has yet to make its full impact on prosthodontics. Already imaging and diagnostics have been revolutionised while CAD/CAM is changing everyday practice. It's a privilege to be part of this evolution. I'm confident there is far more to come and surprisingly quickly! Nevertheless, I perceive the siren call of technology worship that tempts so many to forget that today's wonderful gadgets are tools, not icons, with which to treat our patients. No articulator in the past treated a patient; no digital device is likely to do so soon.

The BSSPD laudably embraced the future with its last Annual Meeting devoted to the impact of digital technology. I was proud to have been asked to open the programme and wish the organisation success in the years to come.

Membership

We encourage all new and existing members to pay their annual subscription by direct debit - "The smart way to pay". This makes it much easier for our Society to manage our membership and also makes it easier for members - no more need to remember subscription deadlines each year. For those wishing to change payments to direct debit, please contact Kirstin at admin@bsspd.org or download the direct debit mandate form from the Members only area of the website (under 'Council Papers').

DIRECT Debit

Specialist Training: Is it worth it?

Tameeza Tejani & Christos Theocharides

Over the last few years, Dentistry in the UK has been transforming significantly. Currently, with political uncertainty of the future of the NHS and a rise in the cost of living, patient's spending decisions with regards to both private and NHS dentistry have changed. Furthermore, young dentists who have not had the opportunity to develop their skill sets are facing higher litigious risk for lower financial rewards. Society and the rise in social media has encouraged litigation and patient's aesthetic expectations.

Therefore, more and more young dentists are at crossroads, needing to plan for their future by skilling up and undertaking some level of postgraduate training. This can vary from attending conferences and practical hands-on sessions to diplomas, Masters in Sciences (MSc's), Masters or Doctorates in Clinical Dentistry (MClinDent and DClinDent programmes) and even PhDs.

With the current political / social situation, is it worth considering different career opportunities? We would argue against this and say "YES, it is worth specialising" for the following reasons:

1. By specialising, you make yourself a commodity

From GDC registrant data taken in April 2017, there are 40,205 currently registered dentists and 69,226 Dental care professionals registered (1). Table 1 lists the number of specialists on each of the 13 specialist lists. By specialising, you differentiate yourself from the rest. For example, those on the prosthodontic specialist list tend to make up only 1.1% of all registered dentists. High-end practices worldwide constantly seek to employ UK qualified specialists as their level of training is considered equivalent or higher than other countries. Personally, we have both found our employment prospects to be greatly improved by specialising as practices seem to prefer specialists over general dentists due to the limited number of specialists on the UK list. This allows the practices to market their specialist and their practice with a unique selling point.

Specialty Description	Male	Female	Gender Unknown	Total
Dental and Maxillofacial Radiology	14	13	0	27
Dental Public Health	48	59	0	107
Endodontics	211	76	0	287
Oral and Maxillofacial Pathology	19	13	0	32
Oral Medicine	45	24	0	69
Oral Microbiology	3	5	0	8
Oral Surgery	509	217	0	726
Orthodontics	701	672	0	1373
Paediatric Dentistry	57	180	0	237
Periodontics	251	125	0	376
Prosthodontics	344	102	0	446
Restorative Dentistry	220	72	0	292
Special Care Dentistry	92	213	0	305

Table 1: Registrants by Speciality (Registrant report - April 2017 GDC 2017)

2. By Specialising, your mind set changes

Specialist training is not only a qualification that would mean an additional post nominals after your title, it is a structured training that teaches you to change your mind set; whether it be understanding of the materials and techniques or embracing up-to-date technology. Additionally, you learn how to interpret research and how to implement

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this evidence based dentistry into your daily practice.

Specialist training widens career options for dentists. It allows dentists to learn how to plan and treat complex cases both in hospital and practice environments and teaches them how to provide high level care within a multi-disciplinary team. A few training programmes include some degree of teaching where the postgraduate trainees are involved in teaching and clinical supervision of undergraduate dental students. This can highlight the trainees desire to teach or undertake research posts that can lead to becoming clinical lecturers, mono-specialty consultants or even professors (once a PhD is achieved).

3. By Specialising, you get trained by experts in the field

Dentistry is a practical subject and practical tips learnt from these experts can increase your clinical work to a higher level, increase your time efficiency and reduce stress levels. Furthermore, working under consultants, allows you to establish good relationships with within the dental community. Moreover, during training, as the trainee's practical work is assessed by experts, there is a journey of self-awareness and in turn self-confidence as their clinical work reaches the anticipated higher level.

So I have decided to apply for a mono-speciality programme (Prosthodontics, Periodontics, Endodontics), how can I maximise my chances of getting in?

Before considering an application to any mono-speciality programme, one should read specific guidance to that speciality. A Reference Guide for Postgraduate Dental Specialty Training in the UK (i.e. the dental gold guide (2) is a very useful publication in explaining the role of the GDC, the role of the Joint Committee for Postgraduate Training in Dentistry (JCPTD) (who work through the Royal Colleges) and the role of the training providers (i.e. the Universities, NHS boards and trust/health boards). The GDC's role is particularly important in setting standards for specialty training (3) and awarding "Certificates of Completion of Specialist Training" {CCSTs} which allows entry to the specialist list. Furthermore, certain publications written by restorative consultants may be useful (4).

The GDC requirements for entry include (3):

- Registration with the General Dental Council prior to commencement of training.

- A minimum requirement for entry to specialty training is 2 years of post-graduate foundation training (or equivalent) which may include vocational training (VT) and may also include secondary care in an appropriate specialist environment. Markers of completion of a 2-year foundation training period may include MJDF (Membership of Joint Dental Faculties RCS England) or MFDS (Membership of the Faculty of Dental Surgery RCSEd and RCPS Glasg) or MFD (Membership of the faculty of Dentistry RCSI).

- The essential and desirable criteria for specialty trainees will be included in the person specification for training posts in the specialty. Evidence of excellence (in terms of attributes such as motivation, career commitment etc) would be expected.

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It would be desirable to have research and publications. These are thought to be a useful mannerism to present organisational skills, knowledge and motivation4.

What is expected during a three-year Prosthodontics mono-speciality programme?

The usual training period is a total of 4500 hours over a full-time three-year period or agreed equivalent within the framework of a less than full-time training programme. The programme content should be approximately 15% research, 25% academic and 60% clinical. The research component can be in the form of a laboratory based study, or a clinical based research that may need ethical approval prior to commencing or may be in the form of conducting a systematic review. A 25,000 to 40,000-word thesis is required to be submitted at the end depending if the programme of study is an MClinDent or DClinDent and the trainee has to undertake a viva (oral) examination where they would be expected to present and defend their study. The academic component includes a series of seminars, laboratory practice sessions, self-directed learning, tutorials and case presentations. The clinical component involves restorative and implant consultation clinics and supervised treatment clinics.

In the early stages of training, trainees will be greatly assessed and guided in order to determine their competence base. As the trainees demonstrate clear development of competence, the level of supervision may be decreased. Towards the end of their training, trainees should be confident to act in a more independent way and demonstrate qualities of a newly qualified specialist in the field.

Trainees will be involved in pre and post treatment case discussions. Pre-treatment case discussions can be used to facilitate development of evidence based decision making and planning of the treatment execution. Post-treatment case discussions can be used to reflect on what went well, what could be improved or what alternative treatment options could have been considered.

Generally, training programmes are closely monitored by the local deaneries. For the three postgraduate institutes in London (Queen Mary University, Eastman Dental Institute and Kings College) the London Deanery monitors the training progress and requires trainees to log their cases but also complete certain assessments within each year of their training. These are entered and submitted electronically through an intercollegiate surgical curriculum programme (ISCP). Each year the trainee has to submit a certain number of Cased Based Discussions (CBDs), Clinical Evaluations (CEXs), Direct Observations of Clinical Skills (DOPS), Procedural Based Assessments (PBAs), Multi Source Feedbacks (MSFs), Assessment of Audits (AoAs) and Observations of Teaching (OoT). Specialist trainees are also expected to keep clinical logs of all patients treated and procedures carried out. All these procedures are assessed and graded by clinical lecturers and consultants involved in their training.

Furthermore, each year the trainee has to attend an Annual Review (ARCP) set by the deanery which will assess that the trainee is on track and will sign off completion of that year of training and

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allow the trainee to progress to the next one. The final review meeting is usually carried out after the speciality membership examination. This is considered to be the final sign off for the trainee to be entered on the specialist register.

Throughout this training there are several examinations involved. Each institution has a certain number of examinations including case presentations, viva's and written exams which are required in order to complete the course and be awarded the Masters degree. Upon completion of the training the postgraduate if eligible can submit a selection of clinical cases demonstrating excellent skill sets and understanding of their field of speciality and all other restorative disciplines and take the Membership Examination of the Royal College of Surgeons (eg. MPros for Prosthodontics).

What were the main Challenges?

Long-hours, commitment and stress:

During these three years of intensive training, a trainee will be faced with a few challenges and high and low moments. The initial challenge will be getting your mind set back into long hours of studying as you will be entering from a working environment. Irrespective, of undertaking a part-time and full-time programme there will be a noticeable drop in income and a financial burden due to the hours and cost of these training programmes. In our case, our programme was full-time and we had to work over the weekend to be able to fund this. This was very stressful and tiring considering that within the week we had long days of clinics and long hours of studying. However, we had good support networks with other trainees, our consultants and the deanery. In the long run, it is advantageous and highly recommended to work part-time during any postgraduate qualification as you get to practice your knowledge and skills into real primary care setting.

Organisation:

In order to have a fairly smooth three-year training, a high level of organisation is expected. This can be in the form of keeping organised notes but also planning and executing appointment times and treatments in order to maximise clinical and scientific knowledge. Trainees will be recommended to read a vast number of papers and books which ideally should be reading them throughout the course and in a systematic way, instead of leaving them towards the end of each year prior to exams. They should create good summary notes which they can read again closer to the exams and be able to quote the fundamental papers.

The appointment and treatments provided should be carefully planned as well, in order to maximise the number of procedures carried out but also to the anticipated quality. We recommend that trainees plan their diaries themselves, in order to control the above parameters. It is always advised to have read and be well prepared prior to any upcoming clinical procedure and knowing what equipment will be needed in order to avoid wasting time during the clinical treatment session trying to figure what they would need and how they would use it.

Conclusion:

There are disadvantages and challenges during specialist training. One of the major disadvantage of specialist training is the

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financial burden. Despite this, we would still advise that the training benefits outway the disadvantages. So, when asked by dental students or dentists if we would recommend specialising in any field of restorative dentistry, without a doubt our response is always yes.

References:

1. Registrant report - April 2017. General Dental Council (2017) https://www.gdc-uk.org/about/who we-are/facts-and-figures

2. COPDEND. The dental gold guide. Online article available http://www.copdend.org/

3. The GDC Curriculum for the chosen specialty. For example, for prosthodontics: Curriculum for specialist training in Prosthodontics June 2010 https://www.gdc-uk.org/api/files/Prosthodontics%20Curriculum%2006%2010.pdf

4. Critchlow S & Nanayakkara L. A guide to entry into specialist training. British Dental Journal 2012; 212, 35 – 40.

Future BSSPD Webinars

Each webinar will start at 7.30pm and will provide up to 2 hours of CPD. The webinars will remain free to our members (£10 per webinar for non-members). More details and booking via our website.

- **Wednesday 7th March 2018 by Professor Nic Martin "Impressions that are fit for purpose"**
- **Wednesday 4th April 2018 by Professor Paul Hyde "Does the quality of our impressions matter for our patient's quality of life"?**
- **Monday 30th April 2018 by Dr Tony Preston "Gerodontics for the 21st Century"**

Treatment outcomes of maxillary and mandibular removable partial dentures - a retrospective study

Dr Ali Nankali & Dr Maria Kalou

Introduction and Background
Several treatment options are available for multiple tooth loss. Although patients prefer fixed treatment options, the removable partial dentures (RPDs) are still a choice of partially edentulous patients as it is conservative, less time consuming and more affordable (Shaghaghian et al., 2014).

An acceptable RPD should fulfil the dental requirements and provide the patient with a satisfactory solution, preventing further damage to oral structures and improving function, without any complications (Frank et al., 2000, Removable prosthodontics: Indications for removable partial dentures: a literature review, 2006). However, when complications or failures are present, it is important to identify the causes by the examination of particular criteria.

Aims and Objectives
The aim of this clinical audit was to evaluate the treatment outcomes of maxillary and mandibular removable partial dentures (RPDs), identify causes of failures of the dentures and improve quality of care through suggestions based on the results.

Materials and Methods
This audit was based on documentary analysis of data obtained, with approval, from the existing dental files of Barts and The London Dental Hospital. Inclusion criteria included patients undergoing treatment or being treated with RPDs, between 2013 and 2015, in Barts and The London Dental Hospital and were above 18 years of age. Patients that were undergoing or treated with RPDs for first time or those that were under 18 years of age were excluded from this study. The population size was between 900 and 1000, while the sample size was 130 RPDs. The data were analysed using Microsoft Excel programme. A general dental practitioner using criteria drawn from the existing bibliography examined dental records. The formatted Excel sheet had a personal data section, followed by information relating to the RPDs such as the type of RPD, involved teeth and reasons for failing the treatment. The table was formatted in such a way, to illustrate the issues related to factors such as abutment teeth, dentures, acceptance from the patient, possible oral hygienic problems of the participants, further treatment needed and the longevity of each individual denture.

Results
One hundred and thirty (130) RPDs were examined (60 maxillary, 70 mandibular) from patients with an average age of 64 years and was demonstrated, as it is shown in Figure 1, that 49% of the patients had periodontal problems on their abutment teeth, 41% presented with caries, almost 32% had fracture, wear or loss, 20% needed root canal treatment and 16% presented with mobility. In addition, it was detected that on dentures; 60% had retention and stability problems, 34% had fractures, 26% had problem with the acrylic base, 19% had problems with clasps, 15%

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had loosened or loss of artificial tooth, as it is presented in Figure 2.

In terms of patient experience, 40% of patients expressed pain or discomfort, 38% had difficulty in mastication and 27% of patients had rejected their dentures (Figure 3).

Regarding the hygienic issues about 55% were diagnosed with oral hygienic problems. The average longevity of the RPDs was also audited, as it is displayed in Figure 4 and the calculations showed a figure of 4 years.

Discussion

The main reasons of failures of the RPDs based on dental criteria concern the abutment teeth and the dentures. On the abutment teeth was observed the presence of periodontal disease (49%) and dental caries (41%). The RPDs eliminate the ability of self-cleaning in the junction between clasps and tooth surface and this favors the accumulation of microbes. This can result to the above diseases, as well as the need for root canal treatment (20%), mobility (16%) and loss of the abutments (32%). It should be noted that there is gap in the literature for further analysis of the

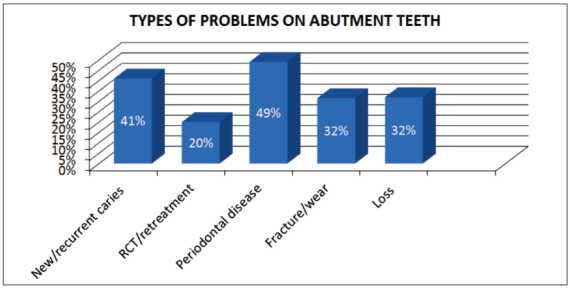

Figure 1: Chart showing the percentages of dental caries, endodontic treatments, mobility, periodontal problems, fracture, wear and loss of the abutment teeth.

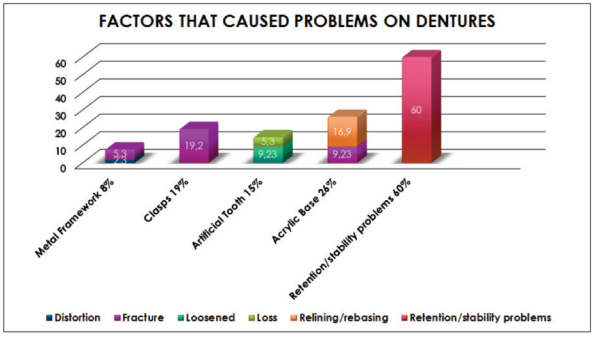

Figure 2: Percentages of unsuccessful RPDs with the associated causes based on the dentures. Complications included problems with the metal framework, the clasps, the artificial teeth, the acrylic base and retention and stability problems.

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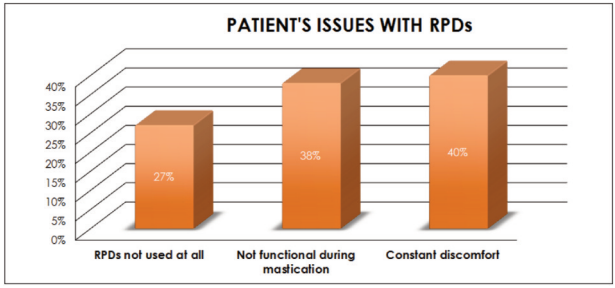

Figure 3: The percentages of the RPDs that were rejected by the patient, difficult or not used for mastication, causing pain or discomfort.

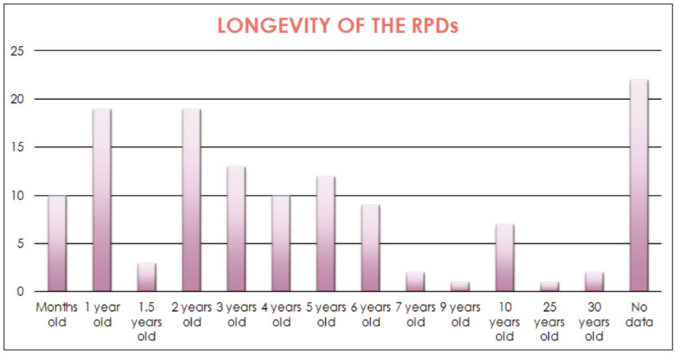

Figure 4: The longevity of the RPDs at different time intervals, ranging between months to 30 years.

progression of periodontal disease due to removable prosthesis. Another complication was fracture and wear of the abutment teeth, on approximately 32% of the participants. In the section of the data collection with the supplementary notes, it was found that many of the participants had parafunctional habits with generalized wear of their natural teeth and decreased occlusal vertical dimension. Further studies in the relation of the RPDs with malocclusion leading to fracture or wear of the abutment teeth should be considered. Moreover, it should be noted that the reduction of occlusal stresses can be provided by correct preparation of the abutment teeth and the appropriate position of the clasps. Parallel guiding planes should be transferred from the surveyor with accuracy in the oral cavity in order to protect the abutment teeth from displacement and fracture caused by lateral and horizontal forces.

On the dentures the main findings were problems with retention and stability (60%), fractures on different parts of the RPDs (34%), problems with the acrylic base (26%) or with clasps (19%) and loosened or loss of the artificial tooth (15%). The main causes related to the above failures were problems with the design, fabrication and surveying during the construction of the dentures, presence of malocclusion or parafunctional habits and misuse of the

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RPDs from the patients (path of insertion and accidental falls). It is known that with time the bone where teeth are lost and extracted becomes gradually more and more resorbed and atrophic. Moreover, another cause could be the poor fitting of the denture as it can harmfully affect the retention and the stability of RPDs.

The third section was focused on patient's criteria. The main complaints were presence of discomfort (40%), RPDs that were not functional during mastication (38%) and others that were totally rejected from the patients (27%). The main causes of these complaints were the inappropriate surveying, design and fabrication of both dentures and abutment teeth preparation. If the cause of failure was from patients' view it was mainly because of the inability to adapt to the change of a new denture.

People older than 65-year of age have impaired neuromuscular control and poorer adaptation to dentures. In addition, material bulkiness, occlusal instability and support can result to discomfort and rejection of the RPDs by the patients.

Conclusion

The findings from this clinical audit demonstrated that treatment outcomes of RPDs mainly depend on factors such as design, surveying and fabrication of the dentures as well as the oral hygiene habits of the patients. The main suggestions for improvement are the development of official guidelines for etiology and management of failures of RPDs, the need of dentists' further training in design and fabrication of RPDs and providing information to the patients for the importance of oral hygiene and recall system.

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Expert Witness Bias

Simon Thackeray

Expert witnesses play an important role in judicial systems of all types. It is vital that they present their opinion evidence in a neutral and impartial manner, and not be subject to bias when presenting evidence. There are many types of bias that can exist within expert opinion, some of it more overt that others, and it is important that steps are taken to identify and neutralize these biases in order that justice is served appropriately and correctly.

Many types of bias are unconscious and cognitive in nature but lead to the risk of amplification of bias if other biases also co-exist, either within an individual, or amongst a group of experts. Other biases may be more overt and due to the values and beliefs of the individual. They may also be present due to a lack of understanding of an expert's overriding duty to the court. Again these may lead to bias amplification when co-existing with other biases, either individually, or across multiple persons.

Methods to identify and neutralise bias within expert opinion exist and have potentially been further enhanced with recent reforms. Some of these methods may prove to be more successful than others in neutralising expert bias.

1 Types of Bias

1.1 Affective Bias

Examples of affective bias include biases such as racism, sexual orientation, or a strongly held moral standpoint. This is a personal bias based on inherent personal views and beliefs held by an individual.

1.2 Cognitive Bias

Cognitive biases are the inherent unconscious errors in the way humans think, and as such are not necessarily subject to control by the individual unless they are made aware of them. It is therefore important to consider that experts that are influenced by such cognitive biases will be likely to be of the opinion that they are acting in a neutral manner, applying what they consider to be an objective and impartial thought process, and therefore be unjustifiably confident in their conclusions and opinion as a result, when this may not actually be the case at all. When an expert receives instruction from one side or the other the process of some bias forming may begin, since it is likely that there may be some difference of opinion or a contentious issue being present by virtue of instructions being issued.

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1.2.1 Confirmational & Hindsight/Outcome Bias

This could be described as *'I knew it all along'* or the *'No Smoke without fire'* type of bias. Hindsight bias is a confirmation of one's own preconceptions. One of the examples of type of bias is when an expert tests hypotheses to only confirm the evidence presented, rather than testing for conflicting hypotheses that may well be equally supported.

1.3 Structural Bias

This is an ideological bias. Essentially this is the bias that gives the expert his or her opinion and is based on the experience in a field of practice. An expert by their very nature is therefore going to have structural bias since they may prefer one opinion to another due to it working more effectively in their hands.

1.3.1 Dogma

A dogmatic belief in one's opinion to the exclusion of others is likely to create bias. If the reasons for an experts belief is based on flawed data (in the cases involving Roy Meadow) and/or an inflexibility to accept other views (as with the cases involving Squier) then the outcome of a case will be affected if weight is given to the expert evidence. It may be that this dogmatic opinion is honestly held; but it may be so entrenched as to be inflexible in its application. However, it is a bias nonetheless and there is a fine line between such honestly held opinion based on accepted ideology and a dogmatic belief in a concept to the exclusion of all other explanations.

1.4 Financial

A direct financial interest in the outcome of a case is one of the most obvious biases that could exist. For this reason, the use of Conditional Fee Agreements by expert witnesses is not recommended in the UK .

1.5 Other Aspects

It is possible that personality of an expert may cause a bias that affects jurors (and to a lesser extent judges). A more confident witness may appear a more plausible witness and may consequently influence the decisions of a jury.

The civil courts have mechanisms whereby evidence can be limited or even ruled inadmissible. At the pre-trial stage of proceedings it is possible that the identification of potentially biased expert testimony can be identified and then dealt with accordingly. It may be that a bias is identified that is so great the evidence cannot be seen to be reliable, and therefore this allows a mechanism

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whereby it is not admitted as it may have an adverse effect on the outcome of the case.

2 Solutions

The unconsciously held biases discussed previously may present a court with problems in their identification. More obviously held biases would be simpler to reveal in cross-examination.

2.1 Single Joint expert

The use of a Single Joint expert (SJE) can remove the individual biases of multiple experts in civil cases.

There is a lack of utilization of the SJE, which may be because of an acceptance within some fields that there are often vast ranges of opinions that exist, and therefore multiple experts can present a broader range of opinion from which a choice can be made.

2.2 Concurrent Evidence or 'Hot-tubbing'

This process involves the presentation of the expert evidence simultaneously before the court, with the opportunity for the judge to direct the proceedings appropriately as the true issues where opinion differ in the case are more likely to surface, and more swiftly.

2.3 Regulation of Experts

Regulatory bodies have the power to discipline their registrants, with the ultimate sanction of removing them from the register, effectively ending their career. However, there is no such mechanism for non-regulated occupations to be disciplined in the same manner. An inequality therefore exists, which advances the argument for the separate registration of expert witnesses.

2.3.1 Training of experts

An awareness of the rules of court is the absolute basic requirement of expert training. It would also highly beneficial that there should be included training in the various types of bias.

3 Conclusions

Due to the nature and foibles of human behaviours, it will remain an imperfect situation, which court rules need to make the best of to avoid the more obvious biases, and reliance on robust training to create an awareness of the effect of bias. In the pseudo-adversarial world of regulatory discipline, such as found within the GDC FTP process, it is important that the expert witness does not align themselves with one side or another and remains truly impartial when presenting testimony.

In-Training Award 2017 – Boston University

John Krezel

In September 2017 I was fortunate to be able to spend time at Boston University Goldman School of Dental Medicine department of Prosthodontics, observing both residents and faculty. The three year postgraduate programme in Prosthodontics is the largest in the US and has 8 (predominately overseas) residents per year and is led by Dr Hiroshi Hirayama.

With Dr Hirayama:
Director of the Advanced Specialty Education Program in Prosthodontics

The department had a slightly more destructive treatment philosophy than in the UK with full coverage crowns being primarily used instead of more conservative onlay or composite restorations to restore worn teeth. The dahl principle is not utilised, with likely litigation if it were to be used. Although destructive, the quality of the work produced was excellent, and I was present at a 47 year follow up of a full-mouth reconstruction that still looked perfect.

There is a great emphasis on the need for high quality provisional restorations and I was able to attend an excellent lecture by Dr Gurkan Goktug on this topic.

Impressions for indirect restorations are never taken on the day of the preparation, with the final prosthesis never fabricated until all functional and aesthetics requirements have been met with the provisional. All indirect restorations are temporarily cemented and IOPA taken to check the margins prior to permanent cementation.

Removable Prosthodontics made up the large majority of the work undertaken by the residents with treatment protocols closely following my teaching in the UK. As at the Royal London they have recently started using laser sintered Cobalt Chrome frameworks with good success.

The residents are provided a similar amount of implant experience as in the UK with the focus on treatment planning and restoring, with approximately 10 surgical placements. I learnt a new technique for accurately capturing the soft tissues of an implant restoration. An impression of the provisional in situ is taken, this is then removed and placed into the impression and an analog placed. This is then cast whilst the patient is waiting and provides an accurate representation of the soft tissues around the provisional restoration. Residents complete a similar amount of

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lab work as at Queen Mary's. They are responsible for their own mounting and diagnostic wax ups and are encouraged to complete as much of their own clinical work as is feasible.

Unlike in the UK a research component is not incorporated into the 3 year programme, residents have an option to pursue research by completing an additional 1 year of study for a Masters or 2 years for a Doctorate. Only a minority of the residents intended to pursue this research option and wanted to have academic careers.

A big difference was that unlike the UK, patients at US dental schools pay for their treatment with the price for a single crown being $1000. Treatment plans had to be tailored to patient budgets with some patients simply not able to afford treatment.

Overall, the programme and teaching is very much aligned to that I am receiving at present. Some treatment plans were more destructive than would be completed here, however the execution was excellent with a likely good long-term prognosis.

I would like to thank the BSSPD for this excellent opportunity to experience Prosthodontics in the US and to the Department of Prosthodontics at Boston University for being so welcoming to me during my visit.

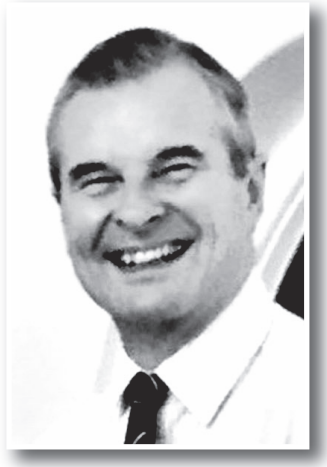
Save the Date...

We may only be just into 2018 but preparations for our 2019 annual conference are well under way. It will be held on Friday 15th – Saturday 16th March 2019 at the Royal College of Physicians in the beautiful surroundings of Regents Park, London under the presidency of Professor Phil Taylor. The theme will be 'managing the heavily restored dentition'.

Obituary

Professor Robin Michael Basker OBE, DDS, BDS, FDSRCS Edin, MGDSRCS Eng, LDSRCS Eng, 1936 – 2017

Robin died on the 4th November at the age of 80 years after a short illness and a long battle with Parkinson's disease.



On graduating in 1961 Robin had a spell in general practice before taking up a lectureship in Dental Prosthetics at Birmingham under Professor John Osborne. He was awarded a DDS in 1969 for his research into dental amalgam and became a Senior Lecturer in 1978. He was then appointed Professor in Dental Prosthetics at Leeds where he strengthened the course by increasing its clinical relevance spurred on by his career-long interest in prosthodontics in general practice, effective communication between dentist and technician, and dental teamwork. Effective communication was one of Robin's many strengths, but regrettably not via his hand writing which was notoriously difficult to decipher, seriously challenging even his most committed of colleagues. He was Dean at Leeds from 1985 – 90.

Robin became the Leeds University's representative on the General Dental Council from 1986 – 2000 where he served on a number of committees including the Education Committee of which he was Chairman for several years. He was very diligent in his preparation for chairing committees and enormously helpful to others. His quiet strength and determination shone through, but he was not demonstrative. He was a GDC visitor to numerous dental schools and undertook a visitation of South African dental schools in the late 1990s. He was also a member of the Nuffield Enquiry into Dental Education. Robin was very popular amongst GDC staff and was seen as a true gentleman. In 2001 he was awarded an OBE for services to dental education.

After joining the British Society for the Study of Prosthetic Dentistry (now the British Society of Prosthodontics) in 1964 Robin became a frequent contributor and was President in 1988-9. He was a co-author of several successful textbooks. One, 'The Prosthetic Treatment of the Edentulous Patient', was first published in 1975, has had several international editions, and is still going strong with its 5th UK edition appearing in 2011. A 6th edition is currently being considered.

Robin was active in the British Dental Association, both locally and nationally, and was a Scientific Advisor to the British Dental Journal. He had a long involvement with the British Standards Institution and acted as Convenor of the International Standards Organisation Committee on resilient lining materials. When there were

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differences of opinion amongst Committee members he kept things calm and civil, handling matters with tact, diplomacy and humour. He made good I.S.O. friends both at home and abroad. The extensive travelling associated with his post provided opportunities for some adventurous overseas holidays. These opportunities cropped up frequently enough for some on the Committee to claim that I.S.O. stood for 'International Sightseeing Organisation'. He was awarded the BSI's Distinguished Service Certificate in 2002.

Robin was very musical and was a great fan of West End shows. He had a fine singing voice and used to be a talented pianist. He and his then wife-to-be, Jacquie, first met while they were members of the London Hospital Choral Society. He joined the Harrogate Choral Society in 1978 and was a member, with Jacquie, for 35 years. In 2005 he became Chairman of the Society and again demonstrated his charm and tact at Society meetings. These were often held at his home sitting around his fine Mouseman dining table beneath which lurked his two Schnauzer dogs who made certain that everybody left when business was completed! On retirement, and while still living in Harrogate, Robin became a popular guide at Fountains Abbey and very much enjoyed the overseas trips to European historic sites with the other guides. About five years ago Robin and Jacquie moved south to Shalbourne, Wiltshire, to be closer to the rest of their family.

Robin is survived by his wife Jacquie, his daughters Sally and Katie, and his granddaughters Robyn and Laura.

John Davenport (with contributions from colleagues, family and friends).

Goodbye to...

We were also saddened by the recent deaths of three of our honorary members and past presidents:

David Berry (president 1967-68),
Roy Storer (president 1968-69)
and Roy MacGregor (president 1971-72).

Our thoughts and condolences to their families and loved ones.

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2010 Robert Clark
2011 Tomas Albrektsson
2014 Peter Farrelly, Peter Frost, Richard Welfare, Paul Wright
2016 Frauke Müller, Johan Wolfaardt