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# The John McLean Archive:
# a living history of dentistry

# Group Interview with Community Service Dentists:

## Leslie Cheeseman, Professor Stanley Gelbier, Sandra Halford, Christine Holmberg, Alan Howe, Roy Jackson, Mitzi Macey-Dare, Robin Rippon, Astrid Stockel, Pamela Usher, Jacob Van den Berg, Jerry (Jeremiah) Walsh, Nigel Williams.

**Interviewer: Stephen Simmons**
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TRACK 00 – 00:06:15

**Stephen Simmons**: We're now recording. This interview is carried out on behalf of the *John McLean Archive: a living history of dentistry* and today's interview is with the group known as the Wallace Collection. They'll all be introducing themselves shortly. Welcome and thank you very much for agreeing to come along and talk with us today. My name is Stephen Simmonds, this is Sophie, this is Stanley Gelbier. The interview is taking place at the British Dental Association and today is the 4th of October 2011. The intention of the British Dental Association Museum is to preserve these recordings, their transcripts and associated photos, documents and artefacts in the John McLean Archive and by being assigned copyright to make them publicly available for research, education and talks through publication in print, electronic media, public broadcast and the internet, whilst protecting the privacy of the interviewees. So any personal information, address, telephone, will not be passed to anyone who wishes to listen to the recordings. Can we start by asking you to introduce yourselves through the microphone, if you'd like just hand it round?

**Roy Jackson**: My name is Roy Jackson. I'm a former Community Dental Services manager from West Sussex. I retired in 1998.

**Pamela Usher**: My name is Pamela Usher. I retired two and a half years ago, I think it's 2009, having been clinical director and lead on Prison Dental Services in Surrey.

**Jerry Walsh**: My name is Jerry Walsh and my time in the community service was spent as a Community Dental Officer mostly in Merton, Sutton and Wandsworth.

**Sandra Halford**: I'm Sandra Halford. I qualified in 1963 and retired in 2003. I worked in both dental practice and the Community Dental Service.

**Mitzi Macey-Dare**: My name is Mitzi Macey-Dare, I was the clinical director of West Surrey, North East Hants and South West Surrey. I qualified from the Royal Dental in 1960 and I retired in 2003.

**Robin Rippon**: I'm Robin Rippon. I've been retired now for about 11 years and I had various roles in the Community Dental Service starting as a school dental officer and ending up as a consultant in Dental Public Health, working for the four Thames Health Regions, South East England. Let me pass on.

**Astrid Stockel**: I'm Astrid Stockel. I worked in general practice in Guildford in 1965 for three years and then I joined the School Dental Service and I stayed there until 2006 when I retired. I was a Community Dental Officer.

**Christine Holmberg**: My name's Christine Holmberg. I started working for the School Dental Service in 1973 and I rose through the ranks and then I became a community dental manager in Kingston and Richmond NHS Trust and retired in 2008.

**Alan Howe**: The name is Alan Howe and I qualified at the Royal Dental Hospital in 1951. I went into general practice and then transferred to the Community Dental Service in 1975 and retired in 1991 as district dental officer for East Surrey Health Authority.

**Leslie Cheeseman**: I'm Leslie Cheeseman. I'm in my 85th year. I've been retired now 20 years. I had a combined dental service in general dental practice and in the Community Dental Service of between 42 and 45 years. Even prior to the start of that I had some connection regarding dentistry because I was shanghaied into the Royal Air Force dental branch as a dental clerk orderly from 1944 to '48. That was an interesting experience because at that time in the Air Force, its Dental Branch actually invented dental hygienists. I don't know if that's generally known. Sir William Kelsey Fry introduced the grade as a pilot scheme which was quite successful. I don't think I need to say more at this stage. Thank you.

**Nigel Williams**: My name is Nigel Williams. I qualified in '73, spent 13 years in general dental practice, then joined the Community Dental Service and worked in that service for another 23 years.

**Jacob van den Berg**: My name is van den Berg. I answer to Van. I qualified at Guy's in 1958 and I worked in general practice and in the Community Dental Service.

TRACK 01 – 00:06:30

**Robin Rippon**: I just want to say a few words about the School Dental Service as it was when I applied to join it. I went to Reading, spoke to the Chief Dental Officer and after about ten minutes he said to me, "You sound like an enthusiastic dentist, the School Dental Service is not the place for you," and he gave me the names of two or three general practitioners who were looking for assistants. So he was expecting the School Dental Service to be somewhere where the lower levels of dentistry were being done. I became a manager of dentists in the county of Surrey. My first day, I

was given a list of all the dental clinics and the dentists and the dental surgery assistants who were in these clinics and told to go and visit them one by one, “but don’t say anything that’ll upset them.” When I tried to do this I was quite amazed to find that of about 50 clinics altogether, there were something like over 30 of them that the chap in charge didn’t know the names of the people who were working there. It really was not, I didn’t feel, very good that the person in charge didn’t know the names of the people who were working at the individual clinics that he was the boss of. That’s the sort of level of the School Dental Service at some stage. It’s improved enormously since then.
Leslie Cheeseman additional information: The work of an orderly was effectively as a male dental nurse with additional clerical responsibilities, plus an early exposure to the work of a dental hygienist.

**Stephen Simmons**: What year did you start, Robin? What year would that be?

**Robin Rippon**: The chap in Reading was something like 1963, ’62, ’63. And in Surrey was 1975.

**Mitzi Macey-Dare**: I actually worked in Surrey as well and I can remember replacing a dentist who had not put in an amalgam for six months. Everything had been filled with Calogen. He didn’t use local anaesthetics and he was a retired colonel. A lot of the people apparently had come out of the army from an administrative post; they’d got absolutely no idea about children’s dentistry. It was an eye opener I must say.

**Robin Rippon**: Can I go back? I’ve remembered something about a school dentist that had the reputation locally as always being on the golf course by 3 o’clock in the afternoon and local general dental practitioners were aware of this, wondering how somebody could be working as a full time school dentist and be on the golf course by 3 o’clock in the afternoon. [Laughter]

**Nigel Williams**: I joined the Community Dental Service in 1986, having been sacked from the practice where I was an associate in general practice because I didn’t cut 20 crowns a week. It was a lovely family practice but then it was taken over by a real go-getter. So I joined the CDS at that stage. The district dental officer when I joined was Mr William Humpherson who was an extraordinary gentleman, very, very, very brilliant in his own way. And very far sighted because I joined before HC(89)2, which I’m sure will be discussed later, but he was already saying to us all that we should start to treat more people with physical and mental difficulties and children particularly with handicaps of different kinds. Very far sighted of him, but difficult for him because a lot of the dentists that were in the Community Dental Service at that time had only treated children and treated them very well, but for quite a long a period. So suddenly they had to convert to a totally different clientele of whom they had very little experience. And with Mr Humperson’s

encouragement this gradually came in so that when the change of the role of the Community Dental Service came in, there was certainly quite a lot of seeds already sown in the mind, so it wasn't such a shock.

**Leslie Cheeseman**: I would like to confirm what Robin Rippon said earlier and indeed what Nigel Williams has said, about the two different natures of the School Dental Service and the Public Dental Service compared with general practice prior to the introduction of Area Dental Officers. I think that was a most significant change, I think, when that grading was invented or whatever you would like to call it. When they arrived it made a difference, their outlook was different and gradually things changed and changed markedly. So that for me was perhaps the most significant change vis-à-vis community dentistry. Followed of course by HC(89)2, and it made a big difference too. It gave us some clout, some official clout, HC(89)2. But nevertheless even at that time for quite a period the other two branches of the service, the general dental service and the hospital dental service, used to look down on the Community Dental Service and would denigrate it, unfairly in my view. There had been a change, a markedly change when the district dental officer came along and he used his clout with HC(89)2 to change the nature of the service.

TRACK 02 – 00:03:06

**Stephen Simmons**: You were talking about 1974 then, the introduction of the Area Dental Officer. Please come in.

**Alan Howe**: Can I just say a few words about my early experience of dentistry? I was pulled out of school at 15 because my uncle, a dentist in North London, lost one of his two dental technicians and persuaded my mother to pull me out of school at 15 to go and work in his laboratory and help out. I got a very good training in doing dental technician work and I can remember making vulcanite dentures, dentures with springs between the dentures, all those sort of things, and suction discs in the palate. That was a good introduction to the dental technician side of it which served me well when I joined the Royal Dental Hospital, that's early days. The big changes there was first of all we started off with foot engine cum cord drive engine, but the first really big one was to the air rotor. That was a really big significant change. Then tungsten carbide burrs, diamond burrs. Then in 1975 I joined John Minton in East Surrey in the Community Dental Service, so I missed the changes of 1974. One of the changes during my time with East Surrey was that we were a bit pushed for funds, getting funds for things, and we only had boiling water sterilisers and air rotors non-sterilisable. One of the big changes was that we an influx of Vietnamese, one in six was Hepatitis B positive, and because of that I was able to insist on ultrasonic cleaners, autoclaves and sterilisable hand pieces. I refitted all the surgeries with those, which was a big improvement.

[2]Health Services Management. Development of Community Dental Services. HC(89)2. London: Department of Health, 1989.

**Sandra Halford**: If I could return to the School Dental Service. I qualified in 1963 and worked part time in dental practice, part time in the School Dental Service. The thing that I found most stressful was the fact that we were short of resources, we didn't have so much as x-ray machines in all of the dental surgeries. So I would just like to make that point.

TRACK 03 – 00:04:08

**Jerry Walsh**: I actually qualified in Dublin in 1974, so I'm sort of an immigrant to this country. I came into dentistry really because my grandfather was a dentist and I spent a lot of time with him, he had a sort of a workshop downstairs. He was a registered dentist, so he came into dentistry in a different way from most of us and I think he was on the original Dental Register in 1921. But when I came to Britain I worked in private practice as an associate dentist for four years and I was pretty horrified at the standard of dentistry that I saw being done, I felt very uncomfortable with it. I looked around at alternatives and I had an older colleague of mine who'd gone into the community service, so I actually contacted the local Area Dental Officer from Merton, Sutton and Wandsworth, where I was living, and I joined the community service in 1978. It was sort of quite mind blowing, really, the different between general practice and the community service. The community service was very laid back in terms of the number of patients seen per day and it took me a little while to sort of get used to that. But I did find that it, essentially, was what you made it, so that just because everybody else was sort of not doing a great deal didn't mean that you didn't, that you had to not do a great deal. You could actually work as much or as little as you wanted really. I stayed in community until I retired two years ago and I found the whole experience really quite satisfying, career wise. I would also say that one of the best things I ever did was to start to actually come to the Community Dental Services group here at the BDA, which was immensely supportive and I think it guided us and saw us through all the changes that happened over the time I was working. So that's all that I want to say for the moment.

**Astrid Stockel**: I worked in the Community Dental Service in Merton, Sutton and Wandsworth. One of the other dentists spoke about seeing handicapped children. I had a school nearby in my patch, Chartfield School, where children attended with various disabilities and they used to be booked in once a week to the clinic. Someone brought them up to the clinic, so about four children would come up from the school. Mr Weedon, our district dental officer had quite an input into the mobile dental service. We had the mobile dental caravan and this used to come to Chartfield School, so it was booked in twice a year, once in the spring term and again later in the autumn term. We used to inspect the children, to give out notices to the parents if treatment was needed. If treatment was needed and consent forms returned and signed, then we could actually see them in the mobile clinic. More children were treated who would

otherwise perhaps not have been seen[3].

TRACK 04 – 00:04:38

**Christine Holmberg**: I arrived at the School Dental Service in 1973, which was just before it moved from the local authority administration into the NHS. I do agree with Robin Rippon and Mitzi Macey-Dare that there did seem to be a lack of discipline at that time, that you could take very long lunch hours and slip off a little bit earlier than happened later on. So there was a shift in attitude, I think. I think it was very rewarding to feel that one was part of the whole NHS structure, no longer part of the school and education service. There were some benefits to me as well. I do remember being offered added years to my pension at that stage [laughs]. Perhaps it was a bit later than that, I think maybe in 1983. But because of that I was able to improve my pension status fairly inexpensively. I don't think that's the sort of answer you're looking for, but I think everything was sort of rectified and regimented. You know, you felt part of a much bigger picture. As I said, the discipline did seem to get tightened up.

**Alan Howe**: I've just thought of a couple of innovations which were big improvements. The change from Novocaine to Xylocaine and Xylotox, that was a very big improvement, we got much more efficient anaesthetic. The other thing was the disposable needles, sterilised by radiation. Previous to that we'd been using needles over and over and sterilising in boiling water. So that was another big innovation. On a lighter note, I remember my days at the Royal Dental Hospital, the dental chairs had wooden seats and the patients used to depart with a pattern either of flowers or in memory of somebody or other on their posteriors [laughs]. So that was one thing. But in the Community Dental Service we did expand the service to deal with handicapped adults, in my area. We set up a dedicated theatre in Royal Earlswood Hospital and got a consultant anaesthetist and a dentist to treat all the inmates in the Royal Earlswood, because with their disabilities the only real quality of life they had was eating their food. I mean they might have eaten it with their fingers, but they enjoyed their food. But they had terrible tooth conditions. With this service they went in for a general anaesthetic and their whole mouth was done in the one visit. So after that they had a more comfortable mouth, better quality of life.

**Nigel Williams**: Quite interesting the terminology that's been used in the room again, which would be severely politically frowned upon nowadays. We've talked about handicapped, I think disabled is a dirty word now, and no longer are patients patients, they must be known as stakeholders or clients, I believe. Which makes my blood boil slightly because when I go to hospital I want to be a patient, I want to be looked after. A little anecdote with that. Shortly after I

[3] Astrid Stockel additional information: The mobile clinic also visited a school for visually impaired children, Linden Lodge and another for children with behavioural problems.

retired I was asked to take part in a General Practitioners bidding group to carry out services for people with diabetes in Croydon. I was asked to try and formulate a name. So I suggested Croydon Intermediate Diabetics Service. Immediately I got an email from a local nurse manager, who was also on the committee, saying, “You can’t call people diabetics, you’re only allowed to call them people with diabetes.” So I said to them, “Oh, well that in that case I’d been a politically incorrect diabetic for nearly 61 years.” I said, “Perhaps I should be called pancreatically challenged.”

TRACK 05 – 00:07:22

**Roy Jackson**: Many years ago I drove through a blizzard to Dorking. We had a senior dental officer study group there. I was given a sheet of paper and asked to write down what I understood by the term ‘change’. Applying that to today’s discussion, I’ve drawn up changes under three headings. Political changes, equipment changes and changes in materials. I won’t go through them all now. I qualified in ’57, at that time I, like Leslie, had to do my National Service. Fortunately I got a national service commission in the RAF dental branch, which was fine. When I left the RAF I joined a practice in Littlehampton, West Sussex with a colleague who is also retired, so I’ll just call him Tom. One of the things that Tom insisted upon was that nobody should ever be turned away from the practice who was in pain, which was all very well but it meant we were constantly working late. I developed a strategy, a preventive strategy. I tried to ensure that anyone who came to me was rendered dentally fit so that he wouldn’t suddenly arrive one morning with a toothache or, worse still, with a swollen face. In 1974 when the Area Health Authorities were introduced I was particularly interested in children and I felt that this would be a good opportunity to change to the School Dental Service. I was fortunate in being able to take over from David Gibbons, who at that time was the Area Dental Officer in Worthing[4]. David had already introduced a preventive dental strategy in the clinic in Worthing. He was already using fissure sealing and adhesive dental materials. I felt I was very fortunate in being in on the beginning, if you like, of one of the changes in dentistry which was the introduction of adhesive materials. I continued my work in preventive dentistry. One of the things we had was a three year old birthday card scheme. Now one gentleman in the room today considered my three year old birthday card scheme a complete waste of time, but I didn’t. I felt that if we had the opportunity to see children at that age before they needed to have any dentistry done at all, that this was the best approach rather than them waiting until they became an emergency and arrived one morning with pain and a swollen face. As far as I was concerned, the worst thing that could happen to me was for one of my regular children to come in to see me with a fat face and as far as I can recall it only happened in a handful of cases over my 40 years in practice.

[4] In 1974 Roy Jackson was appointed as a School Dental Officer and subsequently as a Community Dental Officer in Worthing. He worked in that capacity in the Central Clinic where David Gibbons had formerly been based. He was appointed Senior Dental Officer in the early 1980s and Assistant District Dental Officer/Community Dental Services Manager in the early 1990s.

**Leslie Cheeseman**: If I can build a little bit on what Roy's just said. One of the most significant differences that I found between the two services, because I was in general practice before I became a Community Dental Officer, was that when I joined the Community Dental Service preventive dentistry had a much, much greater emphasis than it ever did in general dental practice. It was quite different. In fact, GDPs [General Dental Practitioners], and I'm not speaking of myself personally, but I used to go to the various local dental committees and they were all so suspicious of preventive dentistry, the general dental practitioners, and it wasn't in their interests to prevent dentistry, if you understand me. I mean, fluoridation made a big difference. I'm surprised no one's said anything about the introduction of fluorides because that has made a significant difference over all of our lifetimes, the introduction of fluorides. There's toothpaste, sealants, etc. It's made a tremendous difference, as can be witnessed by the difference in the child dental surveys. The difference in the DMF [Decayed, Missing, Filled] scores over the last 30 years is quite amazing[5]. But yes, preventive dentistry to me came alive when I joined the School Dental Service. Now I don't know if anybody else wants to comment on that theme, but if not I'd like to say another thing which I found of tremendous difference to me personally was the introduction of relative analgesia. It made a significant difference in how dental phobics could be treated, how the mental handicapped, the physical handicapped, people who couldn't, who were untreatable before or were untreatable in the conscious state[6]. I think I see my friend on my left nodding, he would also confirm that too.

**Nigel Williams**: Yes, I'd love to confirm that. Les was senior dental officer when I joined as a mere dental officer and he taught me the basics of relative analgesia.  And then when Les moved from Croydon and went over to Epsom, he had an extraordinary nurse called--,

**Leslie Cheeseman**: Barbara Davis?

**Nigel Williams**: Barbara Davis and Les used to get on with the drilling and Barbara Davis would do all the relative analgesia chat. So Les just sat back, Barbara Davis would put them under and off Les went. Is that true, Les?

**Leslie Cheeseman**: That's quite right. She had training from me[7].

**Nigel Williams**: Les taught me how to do it and he's an excellent teacher. But also I went on a weekend course in Medical and Dental Hypnosis at the Royal Society of Medicine because it is now a fully recognised procedure. This was extraordinary weekend where they carried out hypnotism on ourselves and one member who is present. Those who

[5] See Appendix A for further information
[6] See Appendix B for further information
[7] See Appendix C for further information

went, some of us were open minded, some were absolutely certain it worked and a couple were certain it didn't and they wanted to be there to prove it didn't. We were given an introductory group relaxation therapy and all during the day this chap had said, "No, doesn't work, doesn't work, doesn't work." During the afternoon session the lecturer said to us, "Would you like to look at," we'll call him Peter. Peter was completely out. During the morning they'd implanted in his mind a signal and the lecturer gave that in the afternoon and he went totally relaxed, just like that, and to sleep. When we brought him back to reality he was totally convinced.

TRACK 06 – 00:02:19

**Stephen Simmons**: Just to say that, for the record, the high speed dental turbine was introduced in 1957. Fluoride toothpaste was first marketed in the UK in 1958 and we're still arguing about a date for relative analgesia. Mr Cheeseman, can you enlighten us?

**Leslie Cheeseman**: Well, as I say, I do know that in the States and in the European Low Countries they used relative analgesia as opposed to GA [general anaesthetic]. In fact, I remember the Festival of Britain, what year was that, that was '51? I was a fourth year student at Guy's at that time and the Dental Society had a group of Danish dental undergraduates over as guests. They wanted to see a GA outpatients' exodontia session, because in Denmark the administration of GA, in relation to dentistry was prohibited at all levels. But instead of having a GA they had relative analgesia, which we didn't understand at that time as the knowledge and practice of the RA technique was unknown to us. We tend to pooh pooh it since what we didn't understand it and it had not been introduced to us by our tutors and therefore we had little or no credibility for the technique. But it wasn't until I joined the Community Dental Service full time in 1977 that Mr Humpherson, who we've spoken about earlier, suggested I attend a course on relative analgesia provided by one of his colleagues from the South West Thames Regional Dental Officers Group, Mr Bristow. The tutor was a man from Harrogate, a senior dental officer whose name I've forgotten. But I went on this course and was astounded at what a difference it made actually. It was a clinical course and it was quite remarkable. I developed a major interest and took it on from there. But I don't think it was known generally in this country before 1978. I think that was when the beginning began[8].

TRACK 07-08 – 00:04:06

**Mitzi Macey-Dare**: I'd just like to take up Leslie on one thing before I go on to what I was going to say, was that I was in

[8] See Appendix D for further information

Chicago in the Dental School and they were certainly using general anaesthetics on children then and they were also using a sort of board they could strap them to, to restrain them. So I mean that was, I can't quite remember when it was, but fairly late in my career. The other thing I wanted to say was with the changes of budget holding. I'm particularly interested in abnormalities of enamel and dentine. When I came across them, which I did quite often, I used to send them up to Professor Winter and he would use them for his examination pupils. When cases had to be paid for by the authority, I wasn't able to send them in the same way. He lost a lot of very interesting cases simply, and I'm sure from all the Trusts, because of that reduction in ability to send round.

**Stephen Simmons**: That would have been when extra contractual referrals were introduced, around about 1996.

**Mitzi Macey-Dare**: Yes. But I saw quite a few cases. I saw quite a few cases, because I was interested, they would be referred in to my clinic and then I would send them up to Jerry Winter.

**Alan Howe**: Just a few words about relative analgesia and Leslie. We used to come up to the Post Graduate Medical Centre to give instruction to students, didn't we? We did that for some time. Interesting case of mine with relative analgesia, I had a young woman from a handicap centre who couldn't speak and she was paralytically scared of dentists. She was referred to me to see if we could do any treatment for her. I eventually managed to persuade that they try relative analgesia and it worked. She eased, you know, settled down, eased. I was able to put a local in, an ID, do some work on her. But the most interesting was that once she was under relative analgesia she could speak normally. Yet when she finished with it, she couldn't speak again, which was, I thought, a most interesting feature.

**Jerry Walsh**: Les Cheeseman was saying earlier about how much he depended on his surgery assistant in relative analgesia and I had precisely the same experience. I wanted to bring up the subject of auxiliaries in dentistry, because when I actually was doing my final I was asked a question by one of the professors about the use of auxiliaries in dentistry and I said I'd never considered it. He said, "Well you'd better because it's going to happen quite soon in your working life." In actual fact I was very, very disappointed throughout my working life that it has taken such a long time and for the other people in dentistry to be recognised fully. I was delighted when the General Dental Council finally brought all that along, particularly the dental surgery assistants who worked so hard for us all and were very sort of unrewarded. The other thing I wanted to say as well at some stage is that perhaps we ought to consider the political aspects of dentistry and all the work that the BDA did over the years in that regard.

TRACK 09-10 – 00:05:48

**Nigel Williams**: During my years in the Community Dental Service we had two dental therapists who worked for us. One was absolutely superb, a lady called Ruth Lovering. I'm ashamed to say I think her dentistry was probably a bit better than mine and her way with particularly challenged children, was absolutely superb. The other therapist we had unfortunately wasn't quite so good, because about two years after she joined us we found out that she couldn't actually recognise caries. Which became very, very difficult because how do you handle that situation? But in the end I think we persuaded her that because she could be a hygienist as well, through their qualification I believe, that that should be the line she went down. So that was how we went through that. Just a little anecdote.

**Leslie Cheeseman**: Just to build on a little bit what Nigel has just said about auxiliaries. The standard of care provided by auxiliaries I found in my personal experience to be absolutely exemplary. They were dedicated individuals, but more than that I think their standard of care, as Nigel has said, rivalled with that provided by dental officers frankly in many cases. This may have been because of the professional supervision that had to be applied to each patient, that the dentist used to have to prescribe the treatment and of course he would see the child again[9]. So you would actually see the quality of care which was being provided. And that may have been a primary reason why it was so good, I don't know. But I mean there was no similar experience in general dental practice[10], nobody else witnessed the sort of work I was turning out unless I happened to be reviewed to a regional dental officer[11] and I never had a problem with those either, but the point was there was an informal policing of dental auxiliaries' work by the prescribing dentist which was only to the good, in my view.

**Stephen Simmons**: Historical note. The first dental auxiliary qualified in 1962, New Cross opened in 1960 and it closed in 1983. So it was open for 23 years.

**Jerry Walsh**: I worked from my earliest times in community, I worked with dental therapists and I found them absolutely superb. They worked exactly to the prescription I gave, if there was any change to be made they would come along to have it sort of authorised. The expanded role for dental therapists that came in shortly before I retired was quite fascinating because these women that I'd worked with over many years suddenly were given the opportunity to do

[9] Leslie Cheeseman addition information: The GDC insisted for supervision of these personnel to be applied to each patient with a written pre-operative prescription of the proposed treatment plan made by a dental professional. Additionally the latter would see the patient again post-operatively and could monitor the quality of care provided.

[10] Leslie Cheeseman addition information: At this time auxiliaries were limited to the Community Dental Service

[11] Leslie Cheeseman addition information: Very limited references were made of individual patients to inspecting Regional Dental Officers by an enquiring Dental Estimates Board.

much more. So I had to sort of help them through and sign them up for the number of cases they needed to be able to give ID blocks and so on. I can't remember the other extra duties they were allowed to do, but certainly the ID block changed everything for them. The other thing was they would, you know, you were saying about the one that didn't recognise dental caries, I found that very often they would sort of see caries where I hadn't seen it. I mean so the care they gave the patients was just absolutely wonderful, I couldn't speak more highly about them really.

**Alan Howe**: Just changing the subject. One of the problems I had was dealing with staff when they wanted to remove a member of staff in the Community Dental Service. I inherited a dentist in one of the clinics who was a manic depressive. When he was on a high he arrived at the clinic riding a motorbike, was wearing tartan trews and tartan hat. But when he got there he used to stand in the corner of the surgery and then sit down on a stool there, facing the corner, never saw any patients. Then when he was on a low, he didn't turn up at all. So I tried to deal with this. I eventually referred him to the occupational therapy department and the doctor there, only to find that the occupational therapy doctor was his wife. Of course she wouldn't back me up. And eventually I actually persuaded him, he was 62 at the time, and I persuaded him that his pension would be made up to the full amount if he retired on health grounds. Eventually he got the message and he did retire on health grounds. He and his wife had a villa in Portugal, and so retired to Portugal and then I believe he propped up a bar there until he died.

TRACK 11-12 – 00:06:08

**Christine Holmberg**: I think Alan meant occupational health, not occupational therapy.

**Alan Howe**: Yes, occupational health.

**Christine Holmberg**: Occupational therapy is helping to people live around the home, with aids. I'm just sort of moving off because I haven't said anything very much. I think for me, qualifying in 1973, the introduction of commercial fluoride toothpaste was a big change. Although you say they were introduced in the '50s, I wasn't aware of them being used widely until the '70s. Sadly I didn't benefit from it because I was born in 1946. I think another big impact was adhesive dentistry that's been mentioned before, because before the introduction of adhesive composites, front teeth, anterior teeth had to be repaired with basket crowns, which was one of the most difficult procedures to carry out and didn't have long term success. Silicate fillings were used, yes they were, they destroyed the tooth basically because acid leached out of them, salicylic acid. Although initially they looked pretty good, because they were matched to the tooth, they disintegrated. A lot of caries, recurrent caries, went round the margins and the acid leached into the pulp. So for me

those were very big changes in dentistry and, for me, revolutionised it. Obviously there were further changes later on but I think those had the most impact in my professional career.

**Roy Jackson**: Referring to dental auxiliaries again. On one occasion I was working on my own in the surgery, my DSA [dental surgery assistant] was ill, and one of the New Cross girls brought her young three year old child to see me. I asked her would she be interested in working as my DSA and she said, “Yes, Mr Jackson, I would. When can I start?” Dental auxiliaries or dental therapists make excellent DSAs and this young woman worked with me for several months on a temporary contract and then left to bring up her family. Some years later I advertised for a DSA and this young woman applied again for a permanent post as my DSA and naturally I found working with her very, very useful. We introduced low seated four handed techniques and she had an uncanny way of knowing what I was going to do next before I knew myself. The instrument I wanted next would already by in her hand before I thought I would need it. Talking about auxiliaries, I qualified in 1957 and we were at that time already using dental hygienists in the hospital. When I joined the RAF our initial training was at RAF Halton where we also had the training centre for dental hygienists in the RAF. One of the things which they had to do during their training was to scale varnish from door handles, a meticulous task which I wouldn’t like to have to do myself. They provided an excellent service in the RAF and when I joined Tom’s practice, which I mentioned earlier, in Littlehampton, we were fortunate to have a dental hygienist also. When I joined the Community Dental Service in 1974 in Worthing, we already had a dental therapist there also. Many years ago there was a trial at what is now the Royal London Hospital Dental Institute. They worked with various combinations of dentists and dental assistants to see which was the most efficient. They found, that a single handed dentist working with a trained DSA provided the most efficient method of delivering services, although in the clinic in Worthing we had a dental therapist with her DSA and myself with my own DSA, and that worked very well I found.

**Mitzi Macey-Dare**: With the introduction of the air-rotor life became much easier for the dentist, but it also introduced the ability to do quadrant dentistry and there was a considerable destruction of sound tooth tissue so that one ended up seeing cracked cusps and I think it caused enormous problems and still probably does. So it wasn’t all good. A lot of people made a considerable amount of money by whipping through the whole mouth and putting in fillings which weren’t actually necessary because you’d have done a school inspection and the child was caries free, for example, you’d go round the next year and there was an amalgam in every tooth. It was a big problem.

TRACK 13 – 00:06:50

**Stephen Simmons**: I just wanted to ask the group whether the introduction of dental treatment for special needs

patients under HC(89)2 resulted in a reduction of dental care for normal healthy children?

**Mitzi Macey-Dare**: Yes. When we did school inspections, I can only talk about my own clinical practice, we would find that a lot of children had just had their dental treatment and it was completed before the inspection, because sending out a card saying the school dentist was coming made the parents think about taking the child to the dentist. I think that possibly now the school inspections are virtually not occurring, there are children, vulnerable children, who are just slipping through the net.

**Leslie Cheeseman**: One of the omissions from this group discussion at the moment, and it could be because none of us here were specialist senior dental officers in this field, but I'm surprised that nobody has mentioned orthodontists because there's been a significant change over the years in the diagnosis of malocclusion and the treatment of it. One of the things which was positive from school inspections was that one could pick up early malocclusions in certain people like just a simple incisor inside the bite which one could rectify fairly quickly without too much orthodontic knowledge or technique[12]. But we found at school inspections, if we were to recommend the straightening of crooked teeth we would get an acceptance from the parent very quickly. What the reason for that was I'm not quite sure. Was it because the general dental practitioners by and large weren't that much interested? There were specialist orthodontists who were in general practice but they were not necessarily to everybody[13]. But I do think that is a pity, one of the reasons I think it is a pity that school inspections are not conducted as frequently as they used to be was that early things, like early malocclusions, weren't picked up.

**Nigel Williams**: In Croydon we were very, very lucky in that we had two large orthodontic practices, one of which was run by a chap called Pat McDonogh and now is run by his son Tim. The quality of service they gave was fantastic and needless to say, being CDS [Community Dental Service], we had to refer quite a lot of very difficult behaviour children to them and they were wonderful and also a lot of, inverted commas, 'normal' children who were unhappy with slight defects of their appearance, but I believe with the new regulations within the contract the orthodontist is not allowed to treat children with relatively minor discrepancies. The sad thing with that was that the orthodontist had no choice but to only do those children privately. So suddenly you had a situation where the rich could afford their children to look lovely and poorer people couldn't.

[12] Leslie Cheeseman addition information: one of the most positive findings from the annual school inspections conducted by the Community Dental Service was that incipient malocclusions were detected early, with notes made on record cards of a suggested optimum timing for either simple interception interventions (such as advancing an instanding incisor over the bite and for any recommendation to be made for serial extractions, or for those more complicated malocclusions which needed onward reference to a more specialist practitioner.

[13] See Appendix E

**Roy Jackson**: Just a note on orthodontics. I was very fortunate in Worthing to be able to work with our local consultant who initially spent a day each month working in the clinic. We were able to have the children with their radiographs and their study models ready to hand. The consultant would diagnose children throughout the day and I would treat where possible. He would put on his waiting list cases which required fixed appliance treatments, which I didn't do. We were able to do interceptive orthodontics and used functional appliances quite a lot. Some of the results with functional appliances were really quite extraordinary. You mentioned the guidelines [HC(89)2] which were introduced and their effect on the Community Dental Service. The effect in West Sussex was for the then Chief Dental Officer to run the Service down and by the time I took over the Worthing and Chichester District in the early '90s I had 2.5 whole time equivalents left to run the community service in West Sussex. So that was the result of those particular guidelines, although again someone who is present in this room today did point out to me that these were just guidelines. They weren't written in stone, they were just guidelines.

**Jerry Walsh**: My impression of HC(89)2 was that in the run up it the community service was almost seeking a role because certainly in the area I worked when we do our school dental inspections I think we found that about 70 per cent or so, and that was my impression, of the children we saw were dentally fit anyway and needed no treatment. Of the 30 per cent we'd send forms to, we might get a response from half of those and of that half, half of them indicated they were going to see their own dentist. Orthodontics, as Les was mentioning, was a draw and we were able to cope with all of that via our community orthodontist that we had where I was working and then latterly referring them on to the outside orthodontic practices which were really superb as well, locally. So I think certainly in my area we regarded HC(89)2 an expanded service taking in people with learning disabilities and people with medical histories and so on, as actually a new and very challenging role for us. Those were very interesting times.

TRACK 14 – 00:01:50

**Alan Howe**: Talking orthodontics, we encouraged and helped one of our dental officers to study orthodontics and obtain her qualification, which was a great benefit to our particular group. At that time the new East Surrey was being built and I made a case to region, quite a hefty lot of paper, for a dental department, a proper dental department in that hospital mainly to treat the huge LCC estate of Whitebushes nearby because the children in that area were not getting much dental help at all. Eventually we did get that dental department built. It was the only place in the hospital that air-conditioned, so it was very good. Eventually I managed to get one session of a consultant orthodontist, borrowed from a Guy's session, so it didn't cost us anything. The unfortunate thing about that was that the department gradually became totally orthodontic and then added oral surgery to it and then no Community Dental Service treatment carried out at all

other than the orthodontics in that department, which I thought was very sad. The Whitebushes Estate never got any help.

**Stephen Simmons**: That is extremely interesting indeed, thank you. Thank you very much indeed for all your contributions this morning. We have another session after lunch and we'll see you then.

TRACK 15 – 00:09:38

**Stanley Gelbier**: In 1967 I was a lecturer in Children's Dentistry at the London Hospital and I was encouraged to apply for the post of Chief Dental Officer of Hackney. Several things struck me, that on the Thursday night I was appointed and by Friday lunchtime all the other 12 Chief Dental Officers telephoned, not only to congratulate me but to say, "Can I help you?" I think that was indicative of the sort of atmosphere which was around, which was quite different to hospitals and general practice. A number of people said to me, "What are you doing that for? You're better than that," which really places sort of on record the status that most dentists thought of the School Dental Service. Now it's partly warranted because there were quite a lot of dentists in the School Dental Service at the time who were dropouts from general practice, they couldn't earn a living. Either they never could earn a living or they were coming to the end of their practising life and their earning capacity was going down, so they joined it. But nevertheless there were also a number of enthusiasts around who were really trying to do things which were better than before. Now at the time we have to remember it's called the School Dental Service because that's what it was, it treating mostly children, 95 per cent of our work was treating school children and there were a small number of preschool children and expectant and nursing mothers. Now the other thing I want to sort of home in on is money, because I had 12 surgeries in Hackney when I took over and within a couple of years I'd totally reequipped them and by the end of another two or three years I had 32 surgeries, all beautifully equipped. The significance was that the School Dental Service, as part of the School Health Service, wasn't in the NHS as I think Les had mentioned before, it was part of local authority and depending on where you were you were either part of the county or in my case the borough. But the significant thing is that 95 per cent, no I think it's slightly more, but roughly 95 per cent of my money in Hackney came from the Inner London Education Authority. And depending on where people might have worked, it might have come from the Surrey Education Authority, Kent or Essex or whatever. The significance was that reequipping my surgeries was petty cash compared to the education budget, so as long as I can up with a good argument, almost invariably I got what I wanted. To help me were these other 12 Chief Dental Officers and we used to meet fortnightly. We'd have lunch and then we'd have a meeting and we planned together what we could get. Now in spite of most of my money coming from the Education Authority, and I was honorary principal school dental officer, my home base was Hackney where I was chief dental officer. But

they were only paying for something like five per cent not only of my salary but the cost of the whole budget. So whenever I went to them and said, “can I have this, that or the other,” I said, “and don’t forget you’re only paying five per cent of the cost,” they said, “well of course, have whatever you want.” Now when we went in 1974 into the Area Health Authority and for the first time graduating if you like out of the School Dental Service into the NHS, on the one hand it was terrific, at long last we were starting to be acceptable to other dentists. But the pot of gold had gone forever. Yes, a lot of advances as you know were made after 1974, but those major advances in terms of spending a lot of money never came back to my knowledge anywhere in the country, not in that same way. The other thing I want to mention is the salaries of school dentists. It was minimal. I can’t remember and maybe for the purpose of the write up of this, that we might try and find out how much school dentists were earning just before the reorganisation, when it was negotiated by the Whitley Council, Dental Whitley Council, and after 1974 when it was just part of the NHS. The salaries went up. And part of it was this new function called Area Dental Officer. Now for the first time dentistry had somebody of a very senior level, at Health Authority level, to represent the whole of dentistry. And that was agreed by the BDA, in fact they made sure the jobs were advertised and open to everybody in the profession, not just school dentists. As a result they had a very, very large salary comparative to other people at that time. They also made sure that the School Dental Service was headed by the Area Dental Officer and that was the salary, whenever you’re negotiating you have to make sure you fight not for the people at the bottom initially, but the people at the top because in salaried situations everything tumbles down. If the guy at the top is earning a lot then the district dental officers, the senior dental officers and so on would also earn a lot. So the whole salary structure of the School Dental Service changed. Before the changeover, for a lot of reasons I won’t go into now, it was decided that School Dental Services would be inspected by the Ministry of Health. And there was a compulsory inspection by dental officers from the Ministry every three years and if you were no good they’d come back on an annual basis. And just after I arrived in Hackney I remember Gordon Potter coming from the then Ministry of Health, they worked jointly between the Ministry of Education and the Ministry or Department of Education, they were joint dental officers. And I remember him coming. And before he came he would ask for all the statistics of the School Dental Service. He wanted to know not only what the service was doing, but what individual dentists were doing. And he had all this information, with his is slide rule in those days, no computers, and he’d work out the average productivity of every dentist before he came. And as chief dental officer I had to account for why some people were doing more than average and some people were doing far less. I had said when I arrived that although we had a big waiting list for treatment, we wanted to do prevention, almost unheard of at the time, 1967. And I was backed by the Medical Officer of Health, but the Ministry came down and thought this was terrible, spending time on prevention when you could be doing treatment. And they put in a report which really slammed the School Dental Service and the report in those days went to the chief officer who was the Town Clerk, who was a legal guy. And I was responsible to the Medical Officer of Health, he was responsible to the Town Clerk. And I remember being sent for, with

the Medical Officer of Health, by the Town Clerk and we had to explain why we thought we were ahead of the game, not behind it. And fortunately he supported us and wrote back to the Ministry that they need to come into this modern age. Years later, when I was doing my PhD, rummaging in the Public Records Office I came across some of these reports and there was the report on Hackney, the one where I'd been inspected and Potter had said, "Our new Chief Dental Officer, called Gelbier, and if he can do half as much as he says, he might be alright." [Laughter] Anyway, maybe that's given you some thoughts as to whether things are better or worse after the reorganisation. And it was then one or two authorities were starting to treat elderly people and the handicapped. Again I had two surgeries for the handicapped at that time and again got heavily criticised 'cause the Ministry said, "It's not within the rules," and the borough, thank god, said, "Sue us." [Laughter]

TRACK 16 – 00:03:17

**Leslie Cheeseman**: I was speaking to Stanley over lunch and I was hopeful that he was going to speak this afternoon on vocational training. And I wonder if we could invite Stanley to have a further comment on vocational aspects in the community service, especially of his experience with the BPMF scheme which applied to the Community Dental Service.

**Stanley Gelbier**: Well yes, I mean the School Dental Service and then the community service, were ahead of all branches of dentistry in education. And chief dental officers, and later Area Dental Officers, piled a lot of money into education both in sending dental officers on courses and also starting vocational training. I think it was the second earliest vocational training scheme started in the community service and we insisted that it was not going to be just a few Community Dental Officers going on a general practice vocational training. We had a committee set up of the four Thames regions at the time and we insisted there should be a four Thames vocational training programme, which took off in a big way and many of you were either trainees or gave tutorials or lectures on those courses and we totally raised the whole standing of the community service by doing that. And not only that, but made all the people coming from the hospitals and general practice aware of the high quality of person in the service. It totally changed the whole picture. I'd said to you before, on purpose, before it was mostly a service of dropouts throughout the country. After vocational training started to take effect, it was the most highly qualified group of people. And I include the hospital people in that. And there were particular people, Humpherson was mentioned before, he always made sure that lots of his people not only were going through vocational training, but also teaching. I mean Les was teaching on vocational training, he spoke about relative analgesia before, that was one of the big things and many of you were going round the country, talking. There was a real hotbed of education when the first courses, the DDPH was started and it was started for overseas dentists, but a number of chief dental officers decided, they didn't know why, but they made sure that

either they themselves or some of their dental officers went on those courses. Eventually they became compulsory for senior people. Before the MSc started, everything was geared towards raising standards and I can't speak highly enough of all of that.

TRACK 17 – 00:02:28

**Nigel Williams**: I'd like to pick up on my experiences of education when I joined the CDS. I was very lucky in that my two senior dental officers, members of this group, Les Cheeseman and Ted Taylor, and they had both been general dental practitioners themselves before they joined so they had that background and both of them were, if I may say so, very common sense people. They had a wealth of experience within themselves which they very kindly shared with me and guided me a lot when I first joined. Later on William Humpherson encouraged me to join an MSc course at Kings run by Professor Stanley Gelbier. Now I only completed part of that course but I saw all sorts of aspects of dental life and sociological life during that, which have always stood me in good stead. Then I transferred over to do DDPH [Diploma in Dental Public Health] with John Bulman. And suddenly I was in educational heaven because being the type of person I am I learn by rote and that was exactly how John Bulman did it. I thought that was wonderful. Some years later I came to a CCCDS lecture here where a gentleman who I will call a dry fingered dentist from the Midlands was lecturing. He had set up a new career pathway which he thought all CDS people should go through, a lot of which was academic, for which I have great respect, but not much was clinical. Three quarters of the way through his lecture he said, "And of course, now we don't want any general dental service rubbish in the CDS." I've never been so upset in all my life and I stood up at the back and called the chairman to attention, I said, "Will you ask the speaker to withdraw that comment?" And he wouldn't. Four of us walked out. We went down the pub, I was genuinely in tears and they were almost in tears because I think a breadth of experience before you join the CDS is very valuable. Thank you.

TRACK 18 – 00:01:42

**Stephen Simmons**: Just an historical note about John Bulman. He was one of the people together with Professor Slack who was responsible I think for the first national dental survey of adults in 1968 and then the first national dental survey of children took place five years later in 1973. And I think that must have had a very profound affect on focusing minds on the oral health of the entire country. [Agreement]

**Mitzi Macey-Dare**: Another great thing which improved the standing of the Community Dental Service was the specialists list. I know certainly when I retired we'd got five paediatric specialists and a variety of others as well, surgical

and... I can't off my head say, but certainly the specialists lists really raised the profile of the Community Dental Service and in fact the Royal Surrey used to call in one of our paediatric specialists to advise when they were doing orthognathic surgery on children.

**Alan Howe**: One problem I found when we increased our remit to include adult handicapped and so on, was that none of my dentists were experienced in denture work at all and we had to set up training to teach them how to make dentures and so on. And that was where my GP training came in very useful.

TRACK 19 – 00:03:57

**Mitzi Macey-Dare**: A number of people who are running the Community Dental Service now have an MBA so that they're pretty highly able to manage a service.

**Nigel Williams: I**f I could just say a word or two about audit. It became a very fashionable thing all of a sudden, and many management consultants were hired by the Department of Health to lecture us on how to do it. But in fact it's a very simple thing, you look at what you're doing and you study it and attempt to improve. I think in Croydon we did a pretty good job of that. It wasn't very esoteric, it wasn't highly statistical, but it was practical. Now if I may link that in with my comments about the rise of the administrator. I went through a whole series of reorganisations when Community Trusts were first formed. When it was first formed the Croydon Community Trust was quite small, led by a wonderful woman call Judy Hargadon as the chief executive, who pulled together the Trust. She knew everybody's name and every lunch time she would go and visit a different clinic. So you always had access to her. But as time went by and different reorganisations came in, the administrative department became bigger and bigger and bigger. It ended up with two administrators, highly paid, appointed to study our audits. And then they called a group of the head of audit for each department to then criticise each other's audits before the audit would finally be accepted by the Authority. I thought that was ridiculous, you know. Profession is a dirty word, but if we're doing audits, we're capable of doing it and all somebody had to do, the chief executive just glance at it and it would be fine.

**Leslie Cheeseman**: A thought has just occurred to me from what Stanley was also saying; there came a stage where available funding became very tight, when the responsibility for the well being of the Community Dental Service was transferred from the Local Authorities to the Health Authorities. I confirm that with my own experience The only safeguard, not the safeguard, the exhaust or whatever you'd like to call it, happened when the Health and Safety at Work Act came in. That made a tremendous difference. I was able to use quite a lot of clout because of that Act in

getting money I couldn't get hold of before. Now I don't know if that is other people's experience.

**Christine Holmberg**: I had some bad experiences with Health and Safety because I often had to do Health and Safety reviews and write up reports and I would send the findings to the Health and Safety officer, but nothing ever got done. And I think money was the problem, you know, that they paid lip service to Health and Safety and insisted on regular auditing, but when push came to shove there was no money up front, you know. It just sort of disappeared into their paperwork on their desk, I think. You were lucky, Leslie, or more forceful.

**Leslie Cheeseman**: Perhaps they realised that they were liable and not me, you see. The higher authority was liable and not me.

TRACK 20 – 00:03:33

**Jerry Walsh**: Just on the subject of education, I saw a whole series of, sort of, dentists come through our service who seemed to spend all their time in education and, you know, were paid salaries all the way through, and gave very little back to the local community, whose money was basically used to provide this education. And I felt a little uncomfortable with that as I watched it over the years.

**Pam Usher**: I counter that with saying that when the membership in clinical community dentistry was introduced, and sadly it's now no longer a qualification, people that sat that exam studied themselves, with no funding, took the exams with no funding, and in fact, it was the precursor of becoming a specialist. So there are instances of people who are quite keen to progress, don't get the funding, and will do so their own time. And that may be an exception in some areas but certainly when I first commenced a post in the city of Portsmouth, in 1971, there was funding in the old School Dental Service as part of the medical officer's budget, I presume, to attend the dental public health course, which was held at the British Dental Association headquarters and that, for me, was one of the big introductions to my further career progression. And to be fortunate enough to have some funding for that, put me in good stead for future career development. And then obviously, motivation to pay for further courses later on in my career, so I think it's not all bad news.

**Robin Rippon**: Certainly to do with this same subject of training, I can remember quite vividly going to one of my staff meetings, one of the six districts, as they were called, and there were two or three people, dentists, out of maybe a dozen, who always went on courses. And they were really disappointed and some maybe even angry that I, as the

boss, said it shouldn't be just those three people going on courses all the time. The money that we had, which was restricted, should be spent on all the staff and it was quite difficult to persuade the three that had always, every year, gone on lots of courses, that they weren't the only ones entitled to it. And I had to encourage the other people to actually look at what they could learn and how they could improve themselves.

**Stephen Simmons**. My introduction to the value of training, I think, came when I interviewed, as part of appraisal, staff who did not appear to be comfortable with special needs patients and staff who did appear to enjoy working with special needs. And the staff who enjoyed working with special needs, had had some training on special needs and they saw them as special needs patients behaving normally. The staff who were not happy with that client group, saw those patients as normal people behaving badly. And it made me realise that a little training can go a very long way in changing the quality of care.

TRACK 21 – 00:06:38

**Leslie Cheeseman**: Right at the beginning of this morning, you said you would welcome memories of things that happened before the Health Service started. One goes back to one's own time as a pupil, when apparently on my entry to infants school in 1931 at age four, I was referred to the School Dental Service, as it then was, and I vividly remember having attended a GA session, where I had all eight deciduous molar teeth extracted at one and the same time. My memory was, it may not have been correct of course, that I was given a gas anaesthetic but I don't believe I was ever sufficiently unconscious for this to take place. It was a horrific experience, as was the severe post extraction haemorrhage afterwards. From that point on, I had a fear of dentistry. Perhaps two years passed and the school dentist came, and I was recommended to have some fillings placed in permanent teeth and my mother signed the form and I duly went to the clinic, where the same dentist as before was on duty. He was, no doubt, a very efficient dentist, technically, but he didn't know how to cope with patients and pain control didn't come into the situation at all. Now we probably all remember having a permanent molar filled, drilled and filled, without locals? A horrific experience. The man couldn't possibly finish my six year old molar because I had memories of the gas session before and I remember this man was just inflicting pain and so the uncompleted cavity was left open to the element. From that point on, I never wanted any dental care again. And it's quite remarkable that I eventually became a dentist. Now the reason I became a dentist, as I said before, I was shanghaied into the Air Force Dental Branch at age 17+. I was under air crew training and they didn't want air crews anymore, so you will be re-mastered to this, this, this and this. And I was re-mastered, compulsorily, to the Royal Air Force Dental Branch, where of course we had a dental inspection and the state of my permanent dentition was a lot worse than it was six years earlier and I needed extensive restoration treatment. But I

could see that the chap that I was working for as a DSA, a Flight Lieutenant Hardy, he was quite a different person to the school dentist because he used locals, and he administered pain control. And that really changed my attitude completely and from that point on, I was interested in following dentistry because he removed pain to prevent fear, and it did precisely that, and that changed my whole life.

**Stephen Simmons**: The role of the salaried services in seeing patients with a phobia became quite prevalent and certainly we saw them. I do remember one patient who told me about the cause of his phobia. He was treated by the School Dental Service and the dentist was an ex-army person, had been demobbed and went straight into the salaried service. And in those days, prior to an extraction, forceps would be dipped in alcohol and then flamed. And this particular dentist had very large, hairy arms as well and this patient said that he had this vision, it happened for real of course, of a man walking towards him with these large, hairy arms, holding a pair of flaming forceps [laughter], with which to extract the tooth. And he said he developed a phobia of dentists and I thought that was an interesting, and very rational, and very reasonable thing to do.

**Stanley Gelbier**: Can we just think about, sort of, how things have changed since the early days? When I did my first school dental inspections, I could stand in front of a class and say smile, and I could say, “You, you, you, you, gas room,” because they had puss oozing out of their mouth, in all parts of the mouth. That was the situation in many, many school children in Hackney. When I first took up post and I looked in the drawer, there was a rule from the old county council who were there before the Inner London Education Authority, and it said, “If you have a gas session booked and there are less than 30 children on the list, cancel it, it’s not worth having.” Yes? And that was more or less the situation in all 12 clinics. At least once a week, we had a gas session with about 30 children. So when people annoyingly say to me at cocktail parties or whatever, “Nothing changes in dentistry,” well all of us, in one way or another, have seen enormous changes. If you’ve got loads of children, you sort of dump a child down, you put a mask over until they turn black, sometimes there was time for a bit of oxygen to be added, the tooth was snatched, or teeth, often many of them, you took them into the recovery room and they were dumped at the head of the queue. And some of you are nodding, so you remember this, you had a sloping basin and if you were lucky, you were the child up at this end, at the top, otherwise at the bottom, they were all dribbling blood and it sort of passed in front of you. So again, when people say it hasn’t changed, it certainly changed in all our lifetimes.

TRACK 22 – 00:03:23

**Pam Usher**: I would like to ask the group a little bit more about their input into the epidemiological studies instigated by

the BASCD [British Association for the Study of Community Dentistry]. I know Sandra had a role in that in South West Thames region. Is there anything we can talk about in that respect and its benefits to the population?

**Nigel Williams**: Perhaps I could answer your question or make a statement here. Well I trained to do the BASCD surveys, I went up to Birmingham, and we speaking earlier about fluoride. At lunchtime somebody was talking about fluoride in Birmingham, they actually had to bus the kids in from outside Birmingham, so that there were some caries for us to look at because the children in Birmingham, from every social strata, didn't have any caries.

**Stephen Simmons**: I had the opportunity many, many years ago, to talk to Professor James about the impact of fluoridation in Birmingham.  e said that within six months of the introduction of fluoride, the number of children needing GAs in Birmingham began to fall and everyone thought, of course, that fluoride took a long time to have an impact. But in fact, there was a topical effect and it was seen within six months of the introduction, which is extraordinary.

**Robin Rippon**: I've recalled a story of when I worked in Slough as a school dentist because Slough had fluoride in the water supply naturally, it wasn't put in deliberately, but it was there. And so people who'd lived many years, children who'd lived many years in Slough had much better teeth. The other thing that Slough did have, though, was a sweet factory called Mars. I could show off at school dental inspections to a visiting person, that I could say I can look at their teeth and identify where their parents worked by looking at their teeth. And on doing a school inspection with a colleague, a dentist, sitting next to me, I could say, "I know where your father works, or your mother works, they work at Mars, don't they?" This kid says yes. And we'd go through another ten or a dozen and get to another one and I'd say, "Your parent works at Mars?" "Yes." And eventually I got to somebody, I said, "Your mum works at Mars?" "No," he said. "Your father works at Mars?" "No." And so this little kid was walking away and this other dentist said, "Well you can't get them all right, can you?" And just as he was going out of the door, the little chap said, "Uncle works at Mars and he lives with us." Why parents did have children with bad teeth is because, if they worked at Mars, they were able to take home free of charge any of the products made in the factory, provided that they weren't wrapped. So they had diets high, very high, on surgery sweets and Mars bars.

TRACK 23 – 00:03:04

**Stephen Simmons**: Just to say something about the early days of the [BASCOT 0:00:06] survey. I was responsible for introducing it into North East Thames region of London, and it was a good time, it was all new. A number of people didn't think it was necessary to participate but eventually they could see the value of it. Because of my training, I

wanted to use a computer and I can tell you that in 1983, a computer was offered to me because nobody else in the health authority could find a use for it. It was surplus to requirements and they thought well, perhaps someone could use it but HR didn't want it, finance didn't want it, stores didn't want it, so I said I'll have it please. And it's just significant, I think, in 1983 people didn't really see the need, or the use of computers for epidemiology or for anything else for that matter.

**Alan Howe**: Just a sad comment about fluoridation. When they privatised the water companies, that was when we lost any chance of fluoridation. I wrote to Thames Water and asked them if they had any intention of fluoridating the water supplies and I got a letter from them, saying that they wouldn't do it unless they were forced to by the government.

**Jerry Walsh**: Just on the subject of fluoridation, we had fluoridated water in Dublin, where I qualified, and I seem to recall, I'm not quite certain, but there was a sort of a change. Up until one particular year, there quite a number of children with dental caries, so there was no shortage of patients to treat, and then suddenly there were none. So I presume it was just the effect of the fluoride working through.

**Mitzi Macey- Dare**: But the only thing is that the poorer children don't actually clean their teeth and therefore they're not getting the benefit of fluoride, so there is a sub-group whose caries rate doesn't seem to have altered very greatly.

**Robin Rippon**: That may be because the effect of a high, sweet Mars Bar diet overcomes, it has a stronger effect on the teeth than the fluoride does.

**Mitzi Macey-Dare**: If they're not cleaning them, though. I'm saying they don't clean them.

**Alan Howe**: About that comment, the beauty of water fluoridation was that it got into the child from birth and it was affecting the teeth as they formed, which was where fluoridation came into its own.

TRACK 24 – 00:01:30

**Nigel Williams**: Just a last comment from me today, I promise, is about retirement. When I first started work in the Health Service, if I went to somebody's retirement, they were usually in tears because they loved it so much and the last thing they wanted to do was to retire. In the last ten years, every retirement party I've gone to, the person retiring has been skipping with joy [all laugh]. Also when I see them a few years later, they look ten years younger than when

they retired. I'm serious about that. I know that working in community dentistry with challenged people is very, very stressful. There are enormous rewards but most nights I'd have a job getting to sleep, worrying about the patient I was going to see the next day, and I think that's part of it. Also the changes in the Health Service, and the administration and the accountability, I think that increased the stress. Certainly, I enjoyed my career. I retired a year early, when I was 59, for which the Department of Health forfeited 15 per cent of my pension, about which I'm very bitter and twisted, but it was a wonderful career and everybody in this room knows it is, but there comes a time to draw the line.

TRACK 25 – 00:06:18

**Stephen Simmons**: Before we leave the topic of fluoridation, I have one anecdote. I have to be rather careful about this. I had to go to a meeting and asked a dental officer if they would carry out the general anaesthetic on my behalf. They said that they couldn't because they had never extracted a tooth and I said, "But surely you must have extracted a tooth during your training?" No, they said they had never extracted a tooth. I was sceptical and asked where they trained. They told me. The dental school was in a fluoridated city. I wrote to the dean and said, "Is it possible that someone would have done the training without?" He said, "Yes it is." He said, "We show them the film, they practice on the pig's head, they get the hand out, they do all sorts of things to show them how it's done but, yes, it's possible they did not extract a tooth because we're fluoridated and we don't get many extractions." So I wrote to the General Dental Council and asked them if they knew about this. They said, "Oh yes." I said, "Well what do you suggest I do?" And they said, "Well train them yourself on how to extract teeth." I wasn't very keen to do that in case anything went wrong and then it would be me, my fault. But fluoridation must have resulted in some dentists qualifying with very little exodontia experience.

**Robin Rippon**: A similar subject but slightly different. I remember interviewing somebody who'd applied for a dental officer job and one of the questions I asked this young lady was, "Would you be happy to treat a child who'd fallen over and broken their front tooth?" And the answer was no. I was a bit surprised that, having qualified as a dentist, they said no they wouldn't be happy to treat a front tooth that had been fractured. And what she said was, "I missed that lecture." So, it's not just extractions. Some people get through dental school with other bits missing as well.

**Mitzi Macey-Dare**: It's very important for community dentists to be good communicators because they have quite difficult patients. I had to carry out an interview for a dental officer with--, and she came--, or two people actually, and one of them was Greek and she brought a translator with her. She hadn't a word of English. Now who she could--, and yet she was, I imagine, on the Dentists Register. And it was an extremely embarrassing situation. Fortunately there was

another candidate who was successful.

**Christine Holmberg**: This is following on from Nigel's comment about, you know, the happiness of retirement and I second that. In my last year or so, we moved to PDS and that really finished it for me. I think I was a community dental gal and I just couldn't cope with, you know, PDS. I didn't like, also, the payment system. I didn't like extracting money from disabled people or getting them to fill HC1 forms, so that they could get their dentures free or cheaply. And I also found that the administration was top-heavy with non-clinical people and it was like wading through treacle, trying to reason with them and get them to understand a clinical point of view. I see that not everybody here has experienced PDS, but perhaps they could make a comment about it because I didn't enjoy it.

**Pam Usher**: I'd second that fully.

**Christine Holmberg**: Oh really?

**Pam Usher**: I think the time that is spent now in administration, or data collection for the sake of data collection because of the ease of access to information with computer studies and so on, and obviously one hopes the service is improving as a result of audits and continuous quality improvement in the service; but I do feel that the service has deteriorated and had so many pressures put on it that I do think so little time now is spent on clinical dentistry. And with the with special care dentistry role we've developed over many years, I do feel it is threatened at the moment because a lot of time is spent by clinicians on non-clinical duties; and it's part of the culture, it's just a different system we're working in these days. And accountability is obviously paramount, we brought up the subject of general anaesthetics earlier and the Poswillo report indicating changes were necessary. Now in the capped salaried dental services, compared with Stanley Gelbier's comments of 30 people a session being treated under general anaesthesia, the hospitals locally in Surrey treat six patients on a session, and each child is admitted more or less as a day case. They have a full general pre-anaesthetic assessment and, following general anaesthetic, they go to a ward and it's very different. Obviously it's necessary for safety reasons but one does wonder how much is absolutely essential and many, many different services now, because of the risk assessments and for instance the other--, sterilisation and the amount of money that has been pumped into infection control, and other aspects that affect the service, rebuilding surgeries because of risk due to other problems, such as CJD. I think the whole service has changed immensely in the last 20, 30 years and it's only if we actually do a timeline of the improvements we can really see we have changed a lot, but I do sometimes wonder if it's all for the better.

TRACK 26 – 00:03:20

**Stephen Simmons**: With just a comment on that. What we've found from interviews with people working in dentistry is that when a change is introduced, it has some beneficial effects that were intended. It also has some negative effects that were unintended or not foreseen. And it is very interesting that just as treatment with an aspirin has benefits or treatment with an x-ray has some benefits, or a diagnostic with x-rays have benefits, they have downsides too. And I think all the changes that we've seen have positive and negative effects and one of the benefits of these oral history sessions is to bring out those aspects, the double-sided coin.

**Robin Rippon**: Could I say something about big changes can have their side effects? I was once able to announce at a dental staff meeting of all dentists and dental assistants and dental therapists and dental hygienists that I had managed to negotiate a pay rise for dental surgery assistants. This was early December and I thought people would think that's wonderful, he's a super boss 'cause he's got a pay rise for his dental surgery assistants who were underpaid. What it actually produced was a sort of grumbled acceptance from the dental surgery assistants, but the dental therapists, who felt that they were slightly higher grade and didn't get a pay rise, were really angry. So that was the downside and I had thought it was going to be wonderful, they're going to be really pleased that the dental surgery assistants were getting a pay rise.

**Stephen Simmons**: Similar event happened where I managed to obtain a situation whereby the staff who were working on Christmas Eve could leave a bit early, ostensibly to do private study. This was met with great joy by some but with fury by others, who thought it was wrong that people who worked full time should have the same amount off time as people who only worked part time. [Laughter] And one learns very quickly that good news for one person is not good news for all. We also had an interesting situation where we had to have rotas which respected the affinities between staff as to who could work with some and who could work with none and who could work with others, it was quite intricate.

**Stanley Gelbier**: It occurs to me, Steve, that one of the things we haven't covered today is dental health education because that clearly is the prerogative of everybody working in this room with the Community Dental Service and I wonder how people feel that they've seen advances in their time, from both the simple chair side and total community type of service.

TRACK 27 – 00:02:06

**Robin Rippon**: I thought dental health, the promotion of dental health education was an important topic and needed an expert to put that topic over and I appointed somebody who was going to be in charge of dental health, promotion of dental health education, who was an ex-teacher. This didn't go down well with anybody in the Community Dental Service because I hadn't appointed somebody who had a dental background. As far as I understood things, teachers could learn a subject and then put it over well but that wasn't acceptable to dental staff and after a few years it wasn't easy for this teacher to continue in her role.

**Stephen Simmons**: I came across a number of dentists who felt that dental health education was not effective in their experience. And with closer cross-examination, it became clear that they didn't fully appreciate the difficulty and the skills involved in changing behaviour. It's quite a difficult thing to do. I participated in a classroom session whereby we set up some baby teeth dissolved in a very, very famous soft drink, which--, and you know they dissolve almost completely within a fortnight, which I thought was wonderful, but I had a letter from the legal department of the famous soft drinks company. One of the children in the class had a parent who worked for the company and was--, the child was horrified to know that the soft drink had these side effects. I had a letter from the legal department, asking me for my observations, and I wrote back and said, you know, let's go to court and we'll see if the experiment is correct. I didn't hear any more.

TRACK 28 – 00:02:44

**Alan Howe**: Yes, I expected all my staff to practice dental health education, both with the patients and especially with the parents.

**Leslie Cheeseman**: It's been confirmed you may preach the message but it doesn't necessarily get through. I think this observation applies no less to those who attempt to improve things by giving scientifically based dental health education. Witness this recent campaign for school children to have a healthy diet, and have healthy school dinners. Some people don't want these school dinners, they want their packed sandwiches from home. It's very, very difficult. You can preach, but you cannot necessarily make sure the message is taken on.

**Stephen Simmons**: We appointed a couple of very well trained oral health promoters, highly qualified for the role, and we had a go at changing the home care regime in some residential homes for adults with profound learning difficulties.

And we found that it took about a year to achieve this because of the high turnover of staff in those institutions and, to some extent, the lack of motivation in them, that it was possible but it did take a lot of effort, far more than we anticipated; including for example, turning up at seven o'clock in the morning when everybody got up, turning up at nine o'clock at night when everybody was going to bed, just to make sure that staff did what it was agreed they would do. Changing the policies that were extant in the institutions, it was possible but it turned out to be quite hard. And if one had tackled it by simply handing out leaflets or writing a memo or whatever, it would have had absolutely no effect whatsoever. So I think it is a very effective means of improving oral health and prevent disease but it takes far more time and resources and skills, I think, than I certainly appreciated at the very beginning.

TRACK 29 – 00:03:53

**Stanley Gelbier**: In one of the earliest toothpaste trials they gave out fluoride toothpaste and of course, as we all know, as has been suggested, if you say to people use it every morning, every night and six months later you go round to people's homes, you say how often are your children using the toothpaste and the brushes which we supplied, they'll tell you morning and night time. But what this person organising the trial did is he got the person doing the home visit always to ask, can they use the lavatory. When they went to the lavatory, the checked in the cabinets to see, and in a number of cases clearly the toothpaste had never been opened and the toothbrushes had never been used, so it is a problem, isn't it, as we all know, getting the message across but actually putting it into action. Can I just also mention that in 1963, the Royal Society of Health introduced the first diploma in dental health education in this country. They were so delighted. It was meant really more for school teachers, rather than dentists and possibly dental nurses. They wrote to the General Dental Council to say, you'll be pleased to know that we've just introduced this new diploma in dental health education, and sent the regulations. The GDC wrote back to say, we're very concerned about this development, don't you know that dental health education is what dentists do. And they wrote back to say you're misinformed, education is what teachers do. It was six months later when the GDC made a pronouncement in the presidential address to say we've given this subject deep thought and we think dentists in practice know best and they should know when their dental nurse is sufficiently well taught to be able to do dental health education on behalf of the dentist. And who knows, maybe there might be a diploma in dental health education to aid them in their endeavours. But you know, it's the whole profession that always lags behind, including the GDC, behind a few leaders.

**Jerry Walsh**: I just wanted to say about dental health education that, I mean, I think it's perhaps as Mr Gelbier suggested, it's much more than just for the profession really and where I worked, we had one or two dental health promoting people, who were extremely well qualified and they were taking very much a more global view of the whole

subject, with a view to changing society in general and, I mean, it would have taken into account your soft drinks producers, would have taken into account this dispute between the General Dental Council and the teaching profession. So it's like everything to do with health promotion, generally, of which it also forms a part, that it's rather like health and safety, it's everybody's responsibility and I think that viewpoint is coming much more to the fore nowadays, which is again another huge change over the last 30 to 40 years.

TRACK 30 – 00:02:13

**Leslie Cheeseman**: You have asked us for memories of the past, before the Health Service. The formation of the Health Service itself was a major change, actually, and the nature of dental services needed change significantly when it was introduced. For instance, I've already recounted my own miserable appreciation of dentistry early on as a child, but I never remember seeing, as a child, my mother and father, other than with, for upper and lower, vulcanite dentures. And I think that was more or less true of the majority of the population, adult population, in the '30s, the '40s and maybe the early '50s. Alan spoke earlier on this morning of his time as a dental technician, when he talked about vulcanite. I think we all, of my age group, remember virtually every adult person wearing vulcanite dentures with--, prosthetics were all porcelain teeth of the same shade. There've been tremendous changes in prosthesis over my working lifetime. That's all I think I wanted to say about that.

**Alan Howe**: Just to add to that I can remember going on demonstrations at Claudius Ash, when [caladent 0:01:38] came in and we were shown how to do plastic--, acrylic dentures and then Stellon went onto that, and it was a different ball game altogether. When you took vulcanite dentures out of the vulcaniser, the stench was terrible and the dentures were thickly coated with plaster. They were very hard work, cleaning them up and finishing them off, whereas the acrylic dentures came out much more cleanly, much less work to do.

TRACK 31 – 00:03:00

**Astrid Stockel**: I have heard from my own dentist, Mr Dury, and perhaps from other people, that these days at dental school, that students are no longer taught to make full dentures, so I think if they have to learn how to make them, they would have to go on a special course[15].

**Alan Howe**: As a sort of addition to that, I reckon that if the dentist didn't know how to do it, he couldn't tell the

[15] Astrid Stockel additional information: Dental prosthetics was part one of the 3rd BDS course. A student spent 12 months learning how to make full and partial dentures, including chrome cobalt skeleton dentures. It was part of learning dental skills.

technician how to do it.

**Roy Jackson**: Just some observations. When I was a houseman at Manchester, after qualifying in ’57, we very frequently had to try and persuade 18 to 20 year olds that they shouldn’t have a full clearance. It was very common at that time for young women who were getting married at age 21 to request a full clearance and have full dentures, so that their husbands would not be left with the expense of their dental care. Somebody mentioned the number of patients they were allowed to have on a general anaesthetic session. Well the number in Worthing was 17. If I tried to sneak an extra one in, a stethoscope was produced and someone was announced not fit to have a general anaesthetic that afternoon. It always remained at 17. Nobody’s mentioned the work of the Strategy Review Body. I forget what the year was, I would imagine somewhere--, ’78 maybe. I know I’d already joined the Community Dental Service at that time, but one of the findings of the review body was that children should be treated in general dental practice and shouldn’t be treated by the School Dental Service. Now I was inclined not to agree with that, as was an American lady who brought her children to see me and said, “I don’t want my children to be treated by a general dental practitioner. I want them treated by a specialist. And you are the specialist in Worthing, I want you to treat them.” I don’t know whether my colleagues would like to comment on the Strategy Review Body.

**Robin Rippon**: When I was working full time in the Community Dental Service, I also did an evening session in a general dental practice, and alternate Saturday mornings, and quite often I’d get somebody who’d come to see me in the evening, or the Saturday morning, saying, “I don’t want to go to that dreadful school dental clinic, so I’m coming to you for my treatment.” It was quite amusing to me and I didn’t let on that I was actually the person from the clinic that they were complaining about, but it was a source of amusement.

TRACK 32 – 00:03:07

**Stanley Gelbier**: Can I revert to the auxiliaries, which we were talking about earlier? It’s interesting because those of us who worked with auxiliaries, later therapies, realise the quality of the care which they provided and I think that was mentioned earlier. And of course, that wasn’t surprising because they entered dentistry ‘cause they wanted to treat children. Most dentists just wanted to treat adults and children was a sort of by-word. And the other thing was that their course, the one year clinical course, was treating masses and masses and masses of fillings, and so the standard of the fillings that they were doing at the end of the course was far greater than the majority of dental undergraduates were doing at that time. Those of us who worked with auxiliaries were amazed by the contribution they made and, at one time, I managed ten of them at the same time. And the production, the quantity and the quality was superb and yet

when we had the Nuffield enquiry, looking at auxiliaries amongst a number of other things, they commented as they went around the country on the high standard of care which had been reported. And yet in their conclusions, they recommended closing New Cross School, and of course this was all politics because the BDA had got to them and said well if they can't work in practice, they're not going to work anywhere. The London Hospital, particularly Harry Aldred at the time, was quite clever. It said well we agree that it's time for New Cross to be closed but if you can see your way to keeping some form of auxiliary, we would like to train them. And of course, after New Cross was closed, the London went to the Ministry of Health and said, well we did say, and it's published in the document, that we are prepared to train them but alongside dentists. 'Cause that was the cry; they should be trained alongside dentists. I don't know why they said that because some of the best hygienists in the country were trained in the services, not alongside dentists. And the London Hospital, to its credit, picked it up and started a school, not of 60 a year, but of eight a year, and they trained them both as auxiliaries and hygienists so that they could work in practice, waiting for the day when they could work as therapists in practice, which of course now they can do. So that was a little footnote, but a very important footnote because I think if the London hadn't held out at that time, there probably would be no auxiliaries, no therapists today.

TRACK 33 – 00:06:08

**Nigel Williams**: We've been talking about change, huge changes in the Health Service, but now it's 2011 and under a coalition government there is about to be the biggest possible change in the Health Service ever, whereby the commissioning may well be led by general medical practitioners. I've been quietly lobbying my own GP about this, to support the Community Dental Service and he's very sympathetic to it. I vaguely remember Stanley telling me the tale of how dentistry actually came into the National Health Service, together with the medics. Can you refresh my memory on that, Stanley?

**Stanley Gelbier**: There were a lot of issues in 1973, moving towards the reorganisation, which were exactly the same as you're talking about now, and that is the issue of dentistry related to medicine because if you study history, or the history of dentistry, you'll see that there are always--, the surgeons in particular, but doctors in general, said we'd love to help you but we can't. And what we found is, as we were fighting for a place for dentistry in the reorganisation, the 1974 reorganisation, that in general doctors, including general medical practitioners, were supportive of dentistry, unless there was a shortage of money. And then when the chips were down, dentistry didn't get a look in. And part of the reason is because everything else in the NHS arises out of doctors, whether you're talking about speech therapies or psychotherapies or whatever, or nursing, it all relies on the medical team and the dental team isn't part of it. So if you're

short of money, the easiest thing you can do is to get rid of the dental bit and it doesn't make any difference to your service. Having said that, my own experience, and I'm sure other people's experience is, a lot of general practitioners used to say to me, "You know, I don't know what our patients would do if we didn't have a decent dental service." So they realise the benefits, particularly as the community service started making inroads, and it may have been different for me because I was in inner London, and inner London was very different from other parts of the country, but there was bad dentistry going on in a lot of places in London, and they were grateful for the community service to take a lead and try and raise standards. I think it's even more important now that salaried dentists, few that they now are, get at these local medical practitioners who've got the money 'cause that's the trick everywhere, always has been. Who's got the money, and get in quick. No point in sitting back and moaning. If they're the ones with the money, you've got start saying to them, look these are the advantages of having dentistry, whether it's care for the handicapped or whatever, but it hasn't changed.

**Nigel Williams**: Actually, I was thinking back a bit earlier than that, to the actual formation of the National Health Service.

**Stanley Gelbier**: Well again, with the formation of the National Health Service, there were many people who didn't think dentistry should be part of it. The BDA was a bit ambivalent, the BDA thought probably, because you have to realise that a lot of dentists, as well as doctors before the Health Service came in, couldn't earn a living in many parts of the country. There was not enough money to go round and we've already heard about how even after the Health Service, some people were coming in and saying, "Take my teeth out." But usually it didn't lead to any other treatment. The usual treatment was, hang on until pain is so bad, you go to a dentist, you have that tooth out. That was the common picture before the NHS. So doctors weren't really involved in that time and dentists had to fight and had to show, but they did. I mean, there was support from Beveridge onwards, there were reports showing that there was terrible dentistry around but what was shown quite clearly was even if there were a better dental service, in many parts of the country, until there was education, it wouldn't matter 'cause people still wouldn't seek dental treatment. That was the biggest thing that had to be recognised from the beginning, there had to be education to show people it was worth preserving their teeth, alongside putting money into good dental care and good dental education. That's after the health service started, round about the same time, when the dental schools started to expand 'cause it was a three-way process. The whole thing had to move ahead together. But we've seen all these and the biggest lesson is, always, and Stephen and I were talking about that earlier, is with every reorganisation, there will be some disadvantages. Look for the advantages and look for the opportunities and those people sitting in this room who looked ahead and saw the opportunities which were coming were well placed to take those opportunities. And it's got to be the same now, dentists,

local managerial dentists and senior clinicians need to be talking to the GPs who are going to be commissioning. No point in waiting till they take over, it'll be too late.

TRACK 34 – 00:06:31

**Alan Howe**: Can I ask a question? What is the future of the Community Dental Service? My old patch has gone down from nine clinics to two surgeries with two days a week. The whole thing seems to be disintegrating. Is that the general position?

**Stanley Gelbier**: Well of course it's a long time since I retired, so I'm not an expert on the future but what I did used to say, even when I was working and sometimes teaching a vocational training, community dentistry isn't just about buildings, so it never worried me when some of the numbers of surgeries reduced. I was perhaps amongst the first to place Community Dental Officers in local general practices and they were happily--, by the time I retired, happily working and doing the treatment which they would have done in clinics, but as part of the general practice team. So buildings don't worry me, but of course if education is good, you can get to the stage where in fact every GP qualifying can do--, can and wants to do all the work which before the community dentists were doing that. Now if that were to be true, then I'm happy with that. All I want to see is good patient care. The service has been a means to an end, if you still need the service, then I'd fight to the last tooth to make sure we have it. But if via education--, you know, a lot of the schools send their students out, working in clinics or in general practices, finding out how to treat these special patients, and if they do it successfully, as I say, it doesn't worry me whether you have a community service. But you need somebody everywhere to be able to say, what's happening? They need to have their finger on the pulse. I think that's very important. Who that person is, well we'll see what the future brings.

**Pam Usher**: When I was involved in the salaried dental service in Surrey, we developed a very robust structure for referrals into the salaried dental service, which was echoed in other parts of the country and I think seen as a very, very necessary development because we treating with individuals and groups of referrals steadily, exponentially and we had a lot of data to prove it was very worthwhile. Nowadays, the specialists in the salaried dental services are working very closely with the hospital dental services and the tertiary services to provide a seamless care and the emphasis that Mitzi has already made on communication, I think is absolutely paramount because we had extremely skilled clinicians working in conjunction with the people who are in the ENT services in hospitals. So if a child was admitted to hospital for a dental procedure, they could also enable the child to have other investigations at the same time. So if it was a child with particular special needs, who was going to be subject to general anaesthetic, it made very good sense to

work in collaboration with the colleagues in the hospital. And I have seen many now specialists in salaried dental services, in oral surgery or medicine, who are needed by the local hospitals at consultant level, and the think the service has now got a high skill base and its proved that all the emphasis on education has been very worthwhile for those special people.

**Jerry Walsh**: I retired in 2008 and in the last, probably, five years of my working life, I actually found that the skills I needed were lacking really because of the fact that I hadn't--, you know, I was actually ending up with patients on my list who, maybe 15 years before, I would have actually sent to a hospital consultant. But because of the changes that had occurred, there wasn't really any room for that type of patient in the hospital service anymore, so I think this sort of emphasis on, you know, really highly skilled people working very closely with the hospital departments and so on is probably the way I would see the future of what we used to call the Community Dental Service. And I really feel quite strongly that anybody who's going to have a long term career in that sort of side of things is going to actually need a full specialist training, you know, however long it takes. I think it's about 15 years, isn't it, to get a certificate of completion of specialist training. But I certainly felt the lack of that degree of knowledge, and I was glad to retire because of that, because I felt I don't think I was really--, would have been able to treat the patients adequately.

**Robin Rippon**: Talking about working in integrated working within the Health Service, between the community service. So I recall trying to be very efficient, managing several cases where a child was going to have some operation under general anaesthetic, and they also needed dental extractions under anaesthetic, so I was invited into the operating theatre to actually take teeth out under the same anaesthetic as the child was having, perhaps, an ear operation. And on the other way round, I remember inviting an anaesthetist to come to do a dental anaesthetic session, knowing--, no this wasn't a child, this was an adult, going to a general anaesthetic session, to have some teeth removed, but they also needed a bunion incised. So under the same anaesthetic, we managed to get both end of body being treated at the same time.

TRACK 35 – 00:01:36

**Stephen Simmons**: What's been said is interesting and strikes me as illustrating a very general point that I've encountered as well. I for example, inherited a service that had a number of dentists who were part of the School Dental Service and had treated normal healthy children for many years. And I came along and said we're going to start treating special needs, and they were unprepared for that clinically and emotionally and in all sorts of ways. And one does come across in salaried organisations, the world outside changes and the people inside have got to either adapt, adopt or

leave, whatever. And it does raise--, it does mean that managing a service like that does require some tough thinking and an ability, obviously, to encourage people and support people to make the transition, but also to deal with people who can't or won't. So it is quite a difficult role, managing that kind of transition. And you have to remember always, of course, that it's patients' care that is the consequence. It's the quality of care that's the consequence and one can't compromise on that.

TRACK 36 – 00:01:35

**Christine Holmberg**: Could I follow on from Alan Howe's remark about clinics are closing down and then Stanley's response to say it isn't just about buildings? I think the service was changing, it was changing from a sort of locality based service, where there clinics in particular areas, to a sort of specialist service, where they turned it into specialist centres. And as long as the staffing didn't go down considerably, that was the way they presented it. They cut the costs of running part time clinics and everything that was involved in maintaining the structure of the part time clinics and consolidating the workforce into fewer specialist centres. Because I left before the Quality Care Commission came in, but I believe they've extremely stringent rules about decontamination and sterilisation, and of course, it requires a great deal of specialist equipment that's very expensive and has to be maintained constantly. So I suppose they see this as a way of saving money on the infrastructure and not on the clinical care. I don't know if anyone has a comment about that?

TRACK 37 – 00:06:05

**Stephen Simmons**: In response to Christine's point, I faced two, even three, very, very serious disinvestments of 25 to 30 per cent of our operating budget, and making frontline staff redundant, including staff who were treating special needs patients. What was interesting was one particular case, where the son of the chief exec was being treated by the service, so one could not argue that they did not understand what the service was for. It was treating their special needs son but the post was still taken. And I think the pressure on chief execs to see through these fairly horrendous cuts was pretty enormous, and the way in which it was done was also very interesting. I attended a board meeting--, a meeting of the health authority, at which the cuts were being discussed and the chairman asked whether they could have a vote in favour. No hands were raised. He then asked whether anybody was against the cuts. No hands were raised. And he said, "Well it's been passed nem con". And that's how it was done. People I think, were stunned that it could even be considered, but it was done and if you're a manager, you manage and you adapt and you try to produce the least damage possible, and to retain and maintain the best service you can with what you've got. But the Health

Service is a very turbulent place, economically. Some parts of the country have more turbulence than others. Where I was, was very turbulent for all sorts of reasons and it's very hard, but if you're a manager, you manage and you try to minimise the damage. [Laughs] Manage and minimise the damage. But that's what happened and it meant when you're disinvesting you would consider obviously the capital consequences and the revenue consequences, and it was a case of trying to retain the most important bits.

**Female voice**?: Around the workforce?

**Stephen Simmons**: The most important parts of the workforce and trying to decide whether there was any--, I spoke once to a director of finance who said, "Do you realise what's going to happen if we make x, y and z redundant?" I said, "There's going to be nobody locally who can treat adult special needs." And he said to me, "Steve," he said, "every time we make a disinvestment, we get people come out with shrouds, which they wave and say that there's going to be dead bodies in the streets piling up," he said, "It's never happened." So there's a certain sort of cynicism and certain sort of, well, confidence that it'll all work out in the end. What in fact does happen is the costs are shifted. So if provider A stops doing it, the patients all go along to provider B, who picks up and say, oh funny we're getting an awful lot of patients from this area or that area. Why is that? And essentially the reason why these redundancies and the way these cuts are possible is because nobody is actually accounting properly for expenditures in the Health Service. Nobody's actually following where the patients – well they never used to follow properly where the patients go or where the money flowed. It was always absorbed within the totality, but I think that's changing now with computerisation and with contractual arrangements. I think now it is becoming very obvious, for example, that if you cut money here, the costs will simply pop up there. If you cut the Community Dental Service, they're going to--, the costs are going to crop up in additional hospital care costs, which the same health authority will have to pay for. And in fact, it's more expensive to have to pay a central London dental teaching hospital to treat patients that could have been treated locally at a far lower cost. We were able to show, for example, that the cost of treating a patient locally under general anaesthesia was considerably below that of a central London dental teaching hospital, with better quality because it was local. We could follow it up with prevention as well, to make sure the patients never darkened our doors again. And in fact from 1984 to 2010, the number of general anaesthetic patients that we had to retreat could be counted on the fingers of two hands. I don't think that's true of patient who attended a London dental teach hospital from the suburbs, anyway. So that's the story, my little story anyway.

TRACK 38 – 00:01:20

**Robin Rippon**: Following that, it's really my view that although, Steve, you say that the patient will be treated under another service and the cost will move somewhere else, in my experience, the treatment just doesn't get done and so the health of the people concerned deteriorates. So it's not actually--, although some of them will move somewhere else, once the service is cut, they just don't get treatment that they desperately need.

**Stephen Simmons**: Just to come back on that, that's probably true in areas outside big cities, in the rural areas [laughs]. In London, I think it's a case of transferring work from one corner--, but yes, I would agree with you as well, Robin, that the net overall effect is probably, as well, a reduction in care provided, as well as some cost-shifting, yeah. So I think we're both right.

TRACK 39 – 00:02:48

**Christine Holmberg**: I'm just adding this because I know that this may be kept for posterity for 300 years. One thing we were talking about earlier was orthodontics. I don't think anyone distinguished between removable appliances and fixed appliances because, when I started there were a lot of practitioners just using removal appliances, and then it became much more difficult to do that. You know, patients had to be properly assessed by a specialist and it meant most cases, they had fixed appliances. Have we talked about implants? I don't know that we have. That's another development of the last few years, where people spend a lot of money to have titanium screws placed in their jaws and crowns put on top, but it's a marvellous thing for people who can afford it. Nobody mentioned colloidal gold. Is it colloidal gold?

**Male voice?**: Cohesive.

**Christine Holmberg**: Cohesive gold, sorry yes. I do remember seeing it done as a demonstration when I was at the Royal Dental Hospital that was an interesting experience. I'm sure there are plenty of other very important developments in dentistry that I haven't mentioned. Can anyone thing of more recent.

**Leslie Cheeseman**: I only wanted to chip in to say that we haven't actually covered John McLean's work on ceramics but Sophie here has written an article very, very recently which is relevant, so we don't need to duplicate what she's written, actually, provided you make sure it gets mentioned in the John McLean Archive.

**Stephen Simmons**: Most definitely, it's in the latest edition of the *BDA News*[16]. It's an excellent article on John McLean

[16] Riches, S, *Redefining Restorations,* BDA News October 2011, p33.

and all the things that he was involved.

**Mitzi Macey-Dare**: Can I say one thing? Children in the past, if they lost a front tooth, would have to have a partial denture until they were old enough for something, perhaps an implant. Now they have an adhesive bridge, which is much better.

**Appendix A**

Leslie Cheeseman additional information provided after the interview:
I would like to build further on the differences between the nature of the services provided by General Dental Practitioners and the Community Dental Officers. Prior to the late 1970s I had spent more than 20 years as a GDP before the first of several NGS re-organisations were made when I then switched to become a Senior Dental Officer in the Community Dental Service. My colleague, Alan Howe, had a similar career experience and we had an adequate exposure of the two services sufficient to make an accurate comparative assessment of the differences between them.
One of the major differences between the two was that the art and practise of preventive dentistry within the Community Dental Service had a much greater emphasis than it ever did in general dental practice. We attended copious meetings where both disciplines were represented and it became clear that GDPs were at least suspicious, or more often antagonistic, towards the beneficial concept of preventive dentistry. It has to be appreciated that at the time GDPs were handsomely remunerated by performing items of service that were treatment orientated and it was perceived not to be in their financial interest to have anything introduced that might negate their need to 'drill and fill', hence their disinterest in most aspects of preventive dentistry which did not feature in the Dental Estimates Board Scale of Fees; whereas most of us who have served within the Community Dental Service know well enough of the long-term beneficial effects of a major reduction in caries experience which follows the introduction of fluoride to water supplies, the application of topical fluoride gels or varnishes, the commercial introduction of the fluoride ion to toothpastes and the selected low dose medication prescribed to young infants, all of which were generally anathema to the primarily caries interested GDP.
The introduction of adhesive fissure sealants around this time also made significant reductions to the incidence of occlusal carious attack and some GDPs were not slow to appreciate that there was potential financial benefit in promoting these as additional sources to their private income (because they were not included in the range of treatments approved for payment by the Dental Estimates Board).
The beneficial effect of the introduction of the fluoride ion in preventive dentistry has been confirmed by the massive reduction of population DMF scores over the past 40 years, highlighted by the comparative results of successive dental surveys that were undertaken by the Community Dental Service during this period.
A 'knock-on' effect of the reduction of caries experience became highlighted in the results of successive adult dental surveys made throughout this period since these have shown that a similar reduction in the young has resulted in an increasing number of adults remaining dentate throughout their lifetimes, with a grossly reduced requirement for the prosthetic provision of full upper and lower dentures, all of which have resulted, in population terms, of sea-change

proportions in the overall improvement of dental health. My interest in preventive dentistry came alive when I joined the Community Dental Service and the reduction in caries experience as a result of the introduction of the fluoride ion in its various forms has been the most signal cause of improvement in dental health of the community at large and has been, indeed, truly amazing.

## Appendix B

Leslie Cheeseman additional information provided after the interview:
Another introduction which I found made a tremendous difference to the quality of care provided by me, personally, was as the result of my initiation to relative analgesia. This provided a fail safe and highly efficient form of conscious sedation, allowing both protective swallow and cough reflexes to remain intact, thereby enabling me to provide hassle-free care to those patients who were to any former degree dental phobics, plus those who presented with physical or learning disabilities. Its major resultant benefits were to markedly reduce the need to arrange for these patients to be exposed to the risks associated with general anaesthesia; to be suitable for administration to patients of all ages without the pre-operative necessity of ensuring the patient had an empty stomach and, finally, enabling them to be cared for as ambulant out-patients. Once patients became ‘converted’ to the technique there was seldom any difficulty in arranging for them to be accept repeated appointments and they never cancelled or failed to attend those subsequently arranged for them without very good and valid reason.

**Appendix C**

Leslie Cheeseman additional information provided after the interview:
Barbara had a natural empathy in providing care to the very young; those exhibiting any degree of physical or mental disability; those in any way fearful of dentistry who had had a former bad experience and she was especially very keen to ensure that any patient's first exposure to operative dental care should be a pleasant experience. She was a lady of inexhaustible patience, prepared to go the extra mile in providing a continuum of conversational (often nonsensical) patter, which transformed patients thoughts to a pleasant and happy environment, remote from the dental setting. As Nigel has suggested, in providing R.A. induction, to all intents she was my right hand, responsible, I suggest, for 90% of my success with the technique.
Barbara became a most valuable tutor for in-service training of DSAs (and often the accompanying dental officers no less!) in her own right. The essence of her ongoing success was her appreciation of the value of the development of efficient teamwork between the dental professionals and their ancillary staff. I was able to secure for her an upgrade to a Tutor DSA which was much appreciated and no less deserved.

**Appendix D**

Leslie Cheeseman additional information provided after the interview:
It was not until 1977 when I joined the Community Dental Service that I heard the term ‘conscious sedation’ again, despite the fact that I had been an elected member of SAAD [Society for the Advancement of Anaesthesia in Dentistry] since 1967. One day my ADO Mr Humpherson suggested to me that he would like me to attend a practical post-graduate course on RA [relative analgesia] to be arranged by one of his South West Thames Regional colleagues, Philip Bristowe and to report back to him my findings at a detailed post-course evaluation. After only a morning series of lectures and a practical demonstration, given by an invioted Senior Dental Officer from Halifax, all participants were encouraged to take an active part by providing conservation under RA to casual patients (not seen before by any of us as operating clinicians) who had arrived at the Community Dental Clinic in the expectation of securing relief from their repeated symptoms of chronic toothache. The results of this limited exposure – fairly accurate description that! – using unfamiliar equipment, at an unfamiliar venue and viewed by a critical audience was outstandingly successful to both operating clinicians and patients, and I became instantly convinced of the effectiveness and value of the RA technique. As a result I developed a major interest in following this up and fortunately so did Mr Humpherson, who found sufficient funding for me to have access to the necessary equipment within a week, arranged for me to provide in-service training to all dental staff and subsequently fitted with RA equipment within a year. That, I think, was in 1978 and a resultant major attention to the technique soon developed in most Community Dental circles, initially throughout the Thames Regions, which rapidly spread to other areas nationally.

## Appendix E

Leslie Cheeseman additional information provided after the interview:
It is worth noting the parents, who following the CDS recommendation for the need for orthodontic treatment, found that many of their own GDPs were not interested in uptake of the orthodontic intervention recommended. The reason for this was unclear. It may have been because the problem of correction was outside the orthodontic skills of the individual GDP but it was puzzling why they did not make such references to specialist orthodontic colleagues known to work in general NHS practice. Many of the latter would only accept those in need of orthodontic care on a private basis. Thus, a two-tier system developed whereby children with affluent parents received treatment and those from poorer backgrounds did not. I understand that annual inspections of children at school are now no longer mandatory and I think this is a pity since evidence of incipient malocclusions (and indeed, other incipient forms of dental pathology) in non-regular attenders may no longer be identified at the most appropriate times for correction.