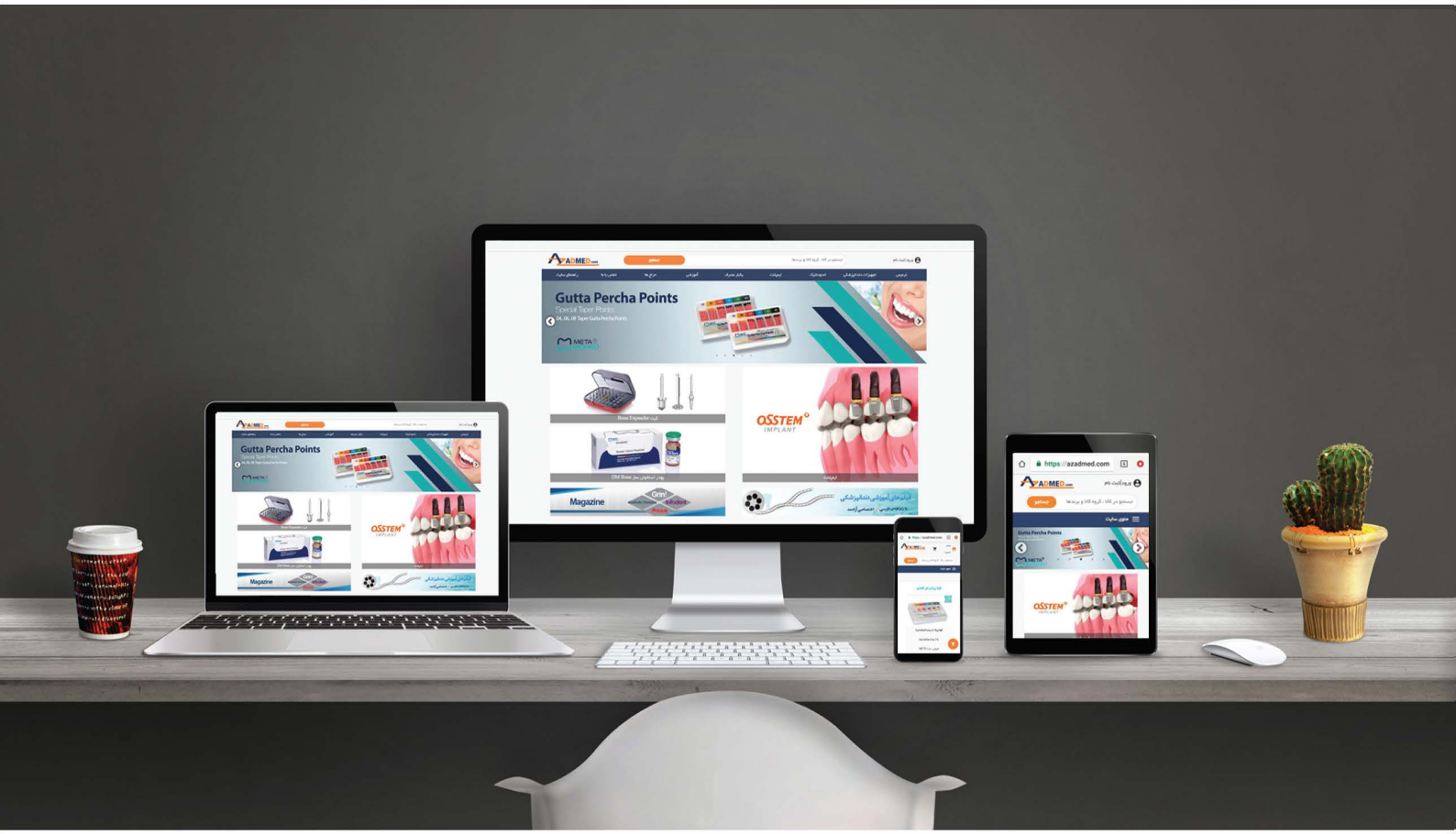
AZADMED.com



www.azadmed.com

azaadtejaratpars

@azadmed2

88 98 80 63 - 6

ESSENTIAL KNOWLEDGE FOR DENTAL PROFESSIONALS IN SCOTLAND

Scottish Dental

AUGUST 2018

RRP £5.50

A profession *in crisis*

PLANMECA Emerald™

Makes your SMILE

YOU DEFINE YOUR PRACTICE. NOT THE TECHNOLOGY.

Scan using the brilliant new ultra light Planmeca Emerald

Design a crown in just a few clicks with our Planmeca PlanCAD® design suite or send files digitally to your laboratory specialist.

Mill a finished crown with the PlanMill®40 S or 30 S in-office.

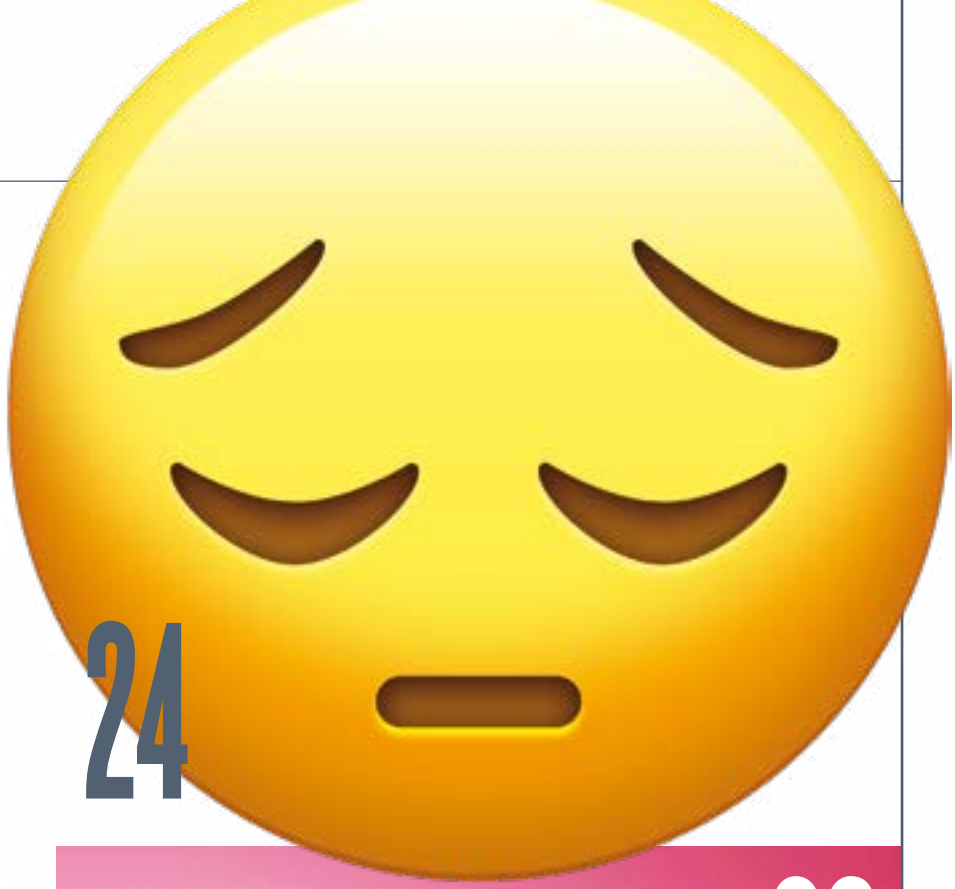
The brand new intraoral scanner Planmeca Emerald™ is a small, lightweight, and exceedingly fast scanner with superior accuracy. Taking digital impressions has never been as easy. It is the perfect tool for smooth and efficient chairside workflow. To arrange your demonstration in our mobile showroom; PlanDemo, visit www.plandemo.co.uk or call us free-phone on 0800 5200 330

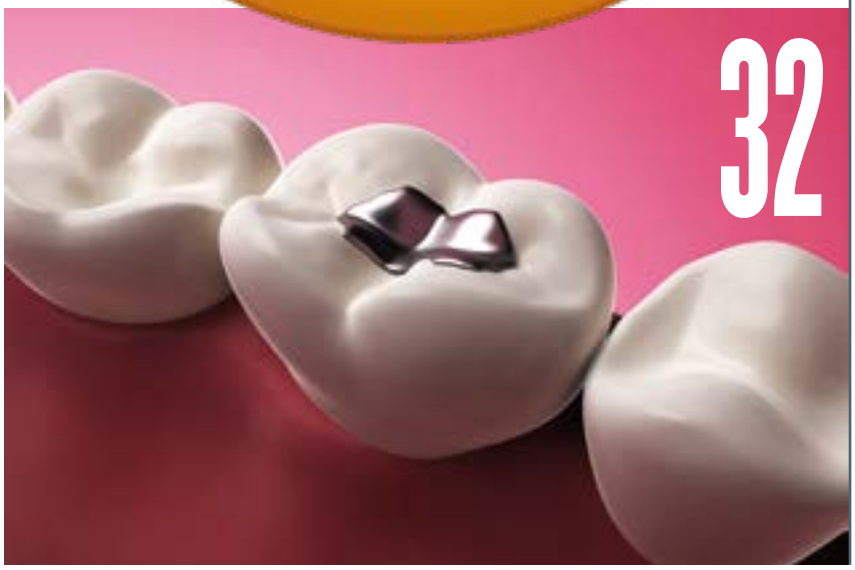
The Crown Jewel of Intraoral Scanning

Planmeca Emerald™

Planmeca UK Ltd, Suite 2, Ricoh Arena, Judds Lane, Coventry, CV6 6GE. Tel: 0800 5200 330 • Email: marketing@planmeca.com

AUGUST 2018





FOLLOW US
SDMAG.co.uk
@scottishdental
scottishdental

Scottish Dental

CONNECT
ENGAGEMENT IS EVERYTHING
connectmedia.cc

MANAGING EDITOR
David Cameron
david@connectmedia.cc

EDITOR
Sarah Allen
Tel: 0131 561 0020
editor@sdmag.co.uk

EDITORIAL
Nigel Donaldson
Stewart McRobert
Tim Power

ADVERTISING
Ann Craib
Tel: 0141 560 3021
ann@connectmedia.cc

DESIGN
James Cargill
Scott Anderson

SUBSCRIPTIONS
Alasdair Brown
Tel: 0141 561 0300
info@sdmag.co.uk

EDITORIAL BOARD
Tony Anderson
Roger Currie
Ulpee Darbar
Dr Michael Davidson
Toby Gillgrass
Professor Mark Hector
Professor Richard Ibbetson
Gordon Morson
Peter Ommer
Andrew Paterson
Professor J Mark Thomason
Dr Donald J Thompson
Professor Angus Walls

ISSN 2042-9762

EDINBURGH
DENTAL SPECIALISTS
SINCE 1994

Patient referrals, second opinions, advice and support, education, dental laboratory services

MEET OUR TEAM OF CLINICIANS...

Dr M Brennand Roper BDS, MClinDent (Pros), MJDF RCS (Eng), MFDS RCS (Ed), MPros RCS (Ed), FDS (Rest. Dent) RCS (Ed)
GDC No. 112806

Matthew is a Consultant in Restorative Dentistry and Specialist in Prosthodontics whose time is split between surgical periodontology, hypodontia and implant therapy at the Glasgow Dental Hospital alongside complex oral rehabilitation at Edinburgh Dental Specialists. His interests include hard and soft tissue regenerative procedures, around which his current research activities are based. Matthew enjoys teaching and spends much of his time training the next generation of consultants at the Glasgow Dental Hospital. Matthew is a Fellow of the Royal College of Surgeons of Edinburgh and is also an examiner for both the Edinburgh Royal College and the Royal Collage of Physicians and Surgeons of Glasgow.

Dr K A Lochhead BDS, MFGDP RCS(ENG)
Clinical Director and Specialist in Prosthodontics, GDC No. 62945

Mr M Paley BDS, MB ChB, FFDRCSI, FRCS, FRCS(Ed)(OMFS)
Consultant Oral and Maxillofacial Surgeon, GDC No. 64778, GMC No. 4398217

Dr C Tait BDS Hons, MSc, MFDS RCS(Ed), MRD RCS(Eng) FDS RCPS (Glas)
Specialist in Endodontics, GDC No. 62862

Dr D Thomson BDS, FDS RCS(Ed), FDS RCPSG, DDRRCR
Specialist in Oral and Maxillofacial Radiology, GDC No. 70079

Dr P Coli DDS, PhD
Specialist in Periodontics and Prosthodontics, GDC No. 104397

Dr P Hodge BDS, PhD, FDS RCS(Ed)
Specialist in Periodontics, GDC No. 56503

Dr G Ainsworth BDS FCS RCPS Glasg, MSc (Ed), MSurgDent RCS (Ed)
Specialist Oral Surgeon, GDC No. 71932

Dr R Philpott, BDS, MFDS, MClinDent, MRD RCS(Ed)
Specialist in Endodontics, GDC NO. 82646

Dr Stuart Campbell, MBDS (Dund) MFDS, RCS, MSc, PG Cert,
Specialist register application submitted GDC No. 79646

Dr C Millen BDS, MClinDent (Pros), MFDS RCS (Ed), MPros RCS (Ed), FDS (Rest. Dent) RCS (Ed), FHEA
Consultant and Specialist in Restorative Dentistry, Specialist in Prosthodontics and Periodontics. GDC No. 85443

Dr Suzanne Lello, BChD Hons (Leeds 2008), MFDS RCS (Ed), MJDF RCS (Eng), FHEA, MOral Surg RCS (Eng)
Specialist Oral Surgeon, GDC No. 153633

Professor L Sennerby DDS, PhD
Professor in Oral Implantology, GDC No. 72826

If you would like to discuss referring a patient please contact our friendly reception team on **0131 225 2666** or visit us online at **www.edinburghdentist.com**
It is our pleasure to be able to offer Second opinions, advice and support from all our clinicians using our tele-dentist service. **tele-dentist@edinburghdentist.com**

Sarah Allen editor@sdmag.co.uk
Follow Scottish dental on twitter at: twitter.com/ScottishDental

Poor reviews for GDC roadshow

Stage-managed production offers audience little in the way of optimism

I should start by admitting that I am a cynic. I think I always have been, but it has definitely got worse with age. This may be because I have seen a lot of political infighting and the damage done by people and factions who are unwilling to negotiate, compromise or work together. But I have also seen the very best of people. Different teams and organisations who do work together, putting differences aside to focus on the bigger picture, the greater good. Much of the best I have seen in healthcare, despite, or perhaps because of, the fact that it is the biggest political football of them all.

This meant that I approached the recent open GDC Council meeting held in Edinburgh with very mixed feelings. On the one hand, here was an organisation that I had heard so many negative things about: their fees are the highest of any regulator, far too high, with reserves that keep going up and up; they are only interested in witch-hunts, the profession live in fear of them; they are out of touch, they don't engage, don't even try and, if you don't work in England – if you don't work in London – then they're just not interested. You name it, I had heard the criticism levelled against the GDC. But... here they were, in Scotland, the Council, the senior staff. They'd spent the previous day meeting people, getting updates, going out to visit practices and services. Now they were having an open Council meeting, with observers, questions from the floor. They were trying, weren't they?

I tried to hush the cynical voice in my head, I really did. I sat down ready to be impressed but, as the meeting went on, that voice got stronger, louder, more insistent. I worked in communications for a long time; I know a PR exercise when I see one, and this was definitely one. It was very well done, but as time went on I felt more and more that I was part of an audience watching a play at a theatre. The actors were impressive, they said the right things, and said them well, but that just heightened the sense that we were watching well-rehearsed actors. The questions from the floor had been pre-selected in the main, and answers clearly prepared. When the panel went, in the GDC's own words, "off-book" and invited impromptu questions from the floor, these weren't really answered. When they spoke about dentistry in Scotland, and the visits and meetings held the previous day I was left with the overwhelming feeling that the whole thing had been like a royal visit. It had been more about being seen to engage and support, than actually engaging or supporting. The people involved still really had no clue what was going on in dentistry in Scotland; but would probably all go back to Wimpole Street having ticked the Scottish box, happy, and not needing to think about it again for a while.

But then I am a cynic. There was every chance I was being grossly unfair, and my experience of the cold-blooded world of PR was colouring the event for me. Unfortunately, it turned out that I was not the only one. Speaking to other people who had been there, many felt the same. We admitted there had been points to promote optimism – when the GDC admitted that "a culture of fear [had] no doubt grown up in dentistry" and that they were trying to erode it. I think they genuinely meant it but, sadly, it will take a whole lot more than one stage-managed event to do that.

However, perhaps all is not lost. If they genuinely meant it then surely there is something to build on? After all, we are entering a period of huge change. A new Cabinet Secretary for Health in Scotland, a new CDO in Scotland (it would appear) and, as I write, an announcement of a new UK Health Secretary too! With change, comes real opportunity. Opportunity to engage, to listen, to learn, to bring people together. In this spirit, I am delighted that this issue we are able to introduce you to our new Clinical Editorial Board. Drawn from across dentistry, they will help support and steer the magazine as we continue to develop it, now and in the future.

I have been struck recently by how often I seem to hear the phrase "but not dentistry". The cap on Tier 2 visas has been lifted for healthcare professionals – but not dentistry. The NHS is free at the point of access – but not dentistry. NHS Scotland employees are getting a 9 per cent pay rise – but not dentistry. Wouldn't it be nice if we could also say, healthcare is riven with political divisions and politics gets in the way of everything – but not dentistry. Ah, says the cynic, typing as the GDC announce that the ARF will remain unchanged for 2019, wouldn't it though...

BIEN-AIR IS NOW AVAILABLE
THROUGH YOUR FAVORITE DENTAL DEALER

Bien Air Dental

36.9°C

PATIENT SAFETY IS MEASURED IN CELSIUS.

Thanks to Bien-Air's patented **CoolTouch+™** heat-arresting technology, EVO.15 is the only contra-angle that never exceeds human body temperature*. Be the one they trust.

EVO.15
CONTRA-ANGLE

SWISS MADE

UP TO 3 YEARS WARRANTY**
www.bienair.com

*at 200,000 rpm when 8N force applied on push button during 10 seconds.
** 2-year standard warranty and 1-year optional warranty available through Bien-Air's PlanCare extended warranty program.

TRY
FOR FREE

TRY EVO.15 1:5 L IN THE COMFORT OF YOUR PRACTICE
Call us at +44 (0)1293 550 200 or go to www.bienair.com and find out more about our 7-day free trial program.

Bien-Air UK Limited Amberley Court Whitworth Road Crawley RH11 7XL England Phone +44 (0)1293 550 200 ba-uk@bienair.com www.bienair.com

Arthur Dent is a practising NHS dentist in Scotland
Got a comment or question for Arthur? Email **arthurdent@sdmag.co.uk**

Mission impossible?

As patients demand increasingly complex treatments for less cost – and often unachievable outcomes – dentists are being forced into a choice of managing unrealistic expectations or losing out to competitors

My last article explored a somewhat technical description of the financial and economic factors squeezing dentists and, in particular, practice owners. This piece is about the expectations of patients and ourselves.

The other day, I had a patient ask to have his veneers replaced because he was getting bleaching done at another practice and he'd like it all done before his holidays in three weeks. I'm quite sure you've all had unrealistic expectations from all sorts of patients, from those wanting everything made perfect yesterday, to implants for a fiver. We are in the business of helping people, making money and maintaining our own personal standards. All of this while developing our repertoire, challenging ourselves to improve and moving with the times. So what did I do? I'll tell you later and you can judge me on it.

Our professional expectations are to be able to work effectively in a good working environment, care for our patients, perform the kind of dentistry we think we should be doing, and get paid reasonably for the job. The problem here is, I believe, we have a degree of unrealistic expectation. We all want to work with the best equipment, best materials and perform 'smile design' and implant cases, because that is what we are told we should be doing in the dental press, by the reps, and by the profession influencers we aspire to become.

We put massive pressure on ourselves when we pay for implant and high-end restorative courses. Or when super expensive business 'gurus' tell us we should be up-selling, to demand higher fees and spend hours talking patients into grand treatment plans organised through our credit providers. I haven't even mentioned the 'digital revolution' – kit costs a fortune and existing workflow is ruined, but I'm sure it'll save us money... eventually... but not on 'the Nash'.

'Too many chiefs and not enough Indians'. Probably a really outdated and culturally inappropriate phrase, but correct nonetheless. It's not possible for everyone to operate at that level. The vast majority of dentistry is unglamorous, simple-but-effective treatment, and someone needs to do it. Our ambition makes this hard to take at times. Especially for young dentists who went to university with sparkling results, pushed through an intercalated degree, and then are encouraged to do fellowships and MSCs because that is what the quality agenda dictates is necessary to be a good dentist. All that work to be doing some amalgams and composites all day long. The reality is going to be spectacularly different.

Speaking of disparity, I see more and more patients with complex dental histories who are not willing to lose teeth, not willing to have dentures but do not have, let's say, a 'good foundation'. Another phrase; 'you can't make a silk purse out of a sow's ear'. However, you have a retired and well-off 50-something of the 'heavy metal' generation in your chair wanting bleaching, multiple crowns and bridge, and an implant to ensure they don't wear a denture and look fabulous on their four holidays a year.

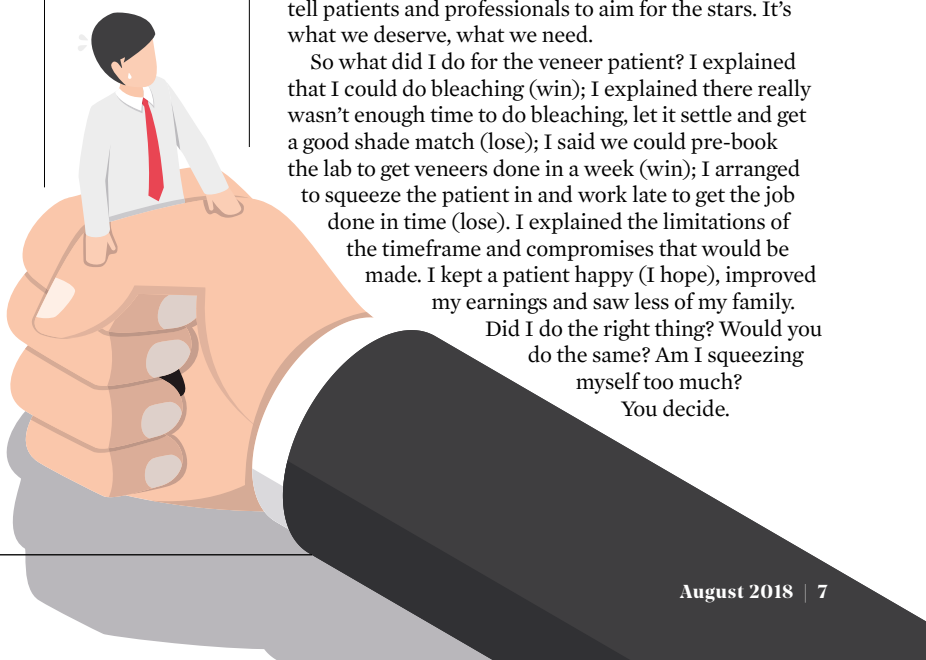
Additionally, they are on the usual cocktail of BP meds, diabetic meds, statins, drink too much (socially; they're very sociable), eat too much and don't have work anymore to create structure for eating and drinking through the day. Their saliva flow and character is tailing off with age and medication, their 30-year-old amalgams are failing with cusps breaking off on their olive stones eaten in the Med and all of sudden the gap that's been there for 10 years is a 'must fill'. They also want this done on the NHS. What was I saying about unrealistic expectations? The problem is, if you don't do it, someone will, or worse, they don't even give you the chance and go somewhere else.

Our personal desires and expectations lead us to try harder, work harder, spend more time 'developing'. This costs us time and money, eats into our work or leisure time to practise techniques that may not benefit our client base and will be likely to have poor uptake as they are high cost items. Our patients demand a wider and wider range of treatments, performed quickly, cheaply and to last a lifetime. We talk constantly about managing expectations, yet the professional and mainstream media tell patients and professionals to aim for the stars. It's what we deserve, what we need.

So what did I do for the veneer patient? I explained that I could do bleaching (win); I explained there really wasn't enough time to do bleaching, let it settle and get a good shade match (lose); I said we could pre-book the lab to get veneers done in a week (win); I arranged to squeeze the patient in and work late to get the job done in time (lose). I explained the limitations of the timeframe and compromises that would be made. I kept a patient happy (I hope), improved my earnings and saw less of my family.

Did I do the right thing? Would you do the same? Am I squeezing myself too much?

You decide.



Introducing our new Clinical Editorial Board

As part of our commitment to grow and develop *Scottish Dental* magazine, provide strong clinical content, create features that are of benefit and interest to you, and showcase the entire dental profession, we have a new Clinical Editorial Board drawn from across the dental world. Our Clinical Editorial Board exists to advise and support the magazine, and we are delighted to welcome its members. As we move forward, we will be adding to the board, so please keep an eye out for announcements.

Tony Anderson

Tony Anderson worked in general dental practice for more than 20 years, becoming increasingly involved in postgraduate education and training before taking up post as a Director of Postgraduate GDP Education with NHS Education for Scotland in 2002. He is currently the lead for the Continuing Professional Development (CPD) workstream, which includes national responsibility for CPD for all dentists and dental care professionals in Scotland, Clinical Audit/Quality Improvement Activity, Remediation and Return to Work support for dental registrants and Mandatory Training.

Roger Currie

Roger Currie FDS, FRCS, FFFST (Ed), FRCS (OMFS) is a consultant oral and maxillofacial surgeon in Ayrshire, with sessions at the QE University Hospital in Glasgow. He has been a Member of Council at the Royal College of Surgeons of Edinburgh since 2010. He is Honorary Clinical Senior Lecturer at the University of Glasgow, Clinical Lead for skin cancer in the West of Scotland, and a past Chair of the Scottish Oral and Maxillofacial Society. He is also an examiner for the intercollegiate FRCS and a Fellow of the Faculty of Surgical Trainers.

Ulpee Darbar

Ulpee Darbar BDS, MSc, FDSRCS(Ed), FDS (Rest Dent)RCS, FHEA is a full-time consultant in restorative dentistry and is also on the specialist lists in restorative dentistry, periodontology and prosthodontics. She is extensively involved in education and training at postgraduate level for dentists, specialists and dental care professionals. She has written the first book on dental implants for dental nurses. She is the Chair of the Advisory Board in Implant Dentistry for the Royal College of Surgeons of Edinburgh. She was the Clinical Director of the Eastman Dental Hospital until 2014 and is now Director of Dental Education for the Trust.

Dr Michael Davidson

Dr Michael Davidson BDS is the Clinical Affairs Lead for Dentsply Sirona UK and Ireland. He received his Bachelor of Dental Surgery from University of Dundee Dental School in 2000. His background includes 18 years in general dental practice, as both an associate and practice owner.

As Dentsply Sirona UK&I Clinical Lead, Michael has overall responsibility for the company's clinician engagement (PEERS), clinical education courses and UK and Ireland-based research activity.

Toby Gillgrass

Toby Gillgrass BDS(Uni Ed) FDS RCSEd, MSc (Uni Gla), MDO RCSP Gla, FDS (orth) RCSEd, FFDT RCSEd, PGDipClinEd(RCPSG) is a consultant orthodontist working in Glasgow, clinical lead for cleft care Scotland and former training programme director for orthodontics for South East of Scotland. He is Chair of the Specialist Advisory Board for Orthodontics for the Royal College of Surgeons of Edinburgh and a member of their Dental Council.

Professor Mark Hector

Professor Mark Hector is the Dean of Dentistry at the University of Dundee and Professor of Oral Health of Children and Honorary Consultant in Oral Health of Children with Tayside Health Board. He is a former President of the International Association of Paediatric Dentistry. He also has a long-standing research interest in Oral Biology and has supervised more than 20 PhD and 50 Masters students.

Professor Richard Ibbetson

Professor Richard Ibbetson BDS MSc FDS RCS (Eng) FDS RCS (Edin) FFGDP (UK) FFD RCSI FRCoA is Director of the Institute of Dentistry at the University of Aberdeen. He is the former Director of the Edinburgh Dental Institute at the University of Edinburgh and Dean of the Dental Faculty of the Royal College of Surgeons of Edinburgh. He is a past President of the British Society for Restorative Dentistry, the Odontological Section of the Royal Society of Medicine and the Royal Odonto-Chirurgical Society of Scotland.

Gordon Morson

Gordon Morson has worked in general practice ever since qualifying from the University of Glasgow in 1998. He works in Alloa and has been a partner in a large NHS practice there for 14 years. He is currently a member of Forth Valley Local and Area Dental Committees and has been involved in dental politics for over 15 years. He also has a significant interest in dental education, having organised Forth Valley's educational programme for dentists and DCPs for more than 10 years.

Peter Ommer

Peter Ommer BDS MBA MPH FDS RCPS(Glas) MJDF RCS(Eng) is Clinical Dental Director for the NHS Ayrshire and Arran Public Dental Service and the overall Clinical Director of Primary Care Dental Services for NHS Ayrshire and Arran. He

Roger Currie

Ulpee Darbar

Peter Ommer

Andrew Paterson

Dr Donald J Thompson

Professor Angus Walls

holds a Master of Business Administration and a Master of Public Health. Previously, he was a principal with two practices. In addition, he also held an appointment as a member of the Scottish Dental Practice Board, between 2007 and 2013, has been a panellist and Chair for the GDC Fitness to Practise committee since 2013, was engaged as a professional adviser to the Scottish Public Services Ombudsman in 2017, and appointed as a dental member of the Scottish NHS Tribunal Service in 2018.

Andrew Paterson

Andrew Paterson is an NHS consultant in restorative dentistry with NHS Ayrshire and Arran. He has worked in both dental and general hospitals in Scotland and England and spent 22 years working in and owning a referral based practice in Glasgow. Andrew has a Masters degree in Medical Law and Ethics and previously worked for a Dental Defence Organisation. He is shortly to take up a post as a Senior Clinical Lecturer/ Honorary Consultant in Restorative Dentistry at Dundee Dental School.

Professor J Mark Thomason

Professor J Mark Thomason BDS, PhD, FDS RCS(Ed), FDS RCPS (Glas), Hon FCDSHK is the Head, School of Dental Sciences at Newcastle University. Prior to his appointment he had been the Director of Dental Education and Degree Programme Director for the BDS Programme and was appointed as Fellow of the Centre for Excellence in Healthcare Professional Education in 2008. He was elected President of the European College of Gerodontology in 2007 and in the same year was also elected President Prosthodontics Research Group of the International Association of Dental Research. Since then he has also served as President of the Geriatric Oral Research Group of the IADR 2008-9 and is the current President of the Nutrition Research Group of the IADR. Mark was appointed to the personal Chair of Prosthodontics and Oral Rehabilitation in 2003 and as an Hon Consultant in Restorative Dentistry Newcastle Upon Tyne Hospitals NHS Trust since 1998.

Dr Donald J Thompson

Dr Donald J Thompson BDS (Ed) FDS RCSEd DDR RCR has worked in paediatric, dental emergency, oral medicine and oral surgery posts in dental hospitals in Bristol, Edinburgh and Glasgow before beginning specialist training in DMFR in Dundee and Glasgow. Since 2016 he has been a part-time consultant in dental and maxillofacial radiology in NHS Lothian, having previously been a consultant in Tayside. His primary role is CBCT and salivary gland imaging. He also works for NES, with responsibility for the dental core trainees in the East and North of Scotland and private reporting of CBCTs. He is a Member of Dental Council RCSEd and an examiner for MFDS, and for DDMFR at the Royal College of Radiologists.

Professor Angus Walls

Angus Walls is a professor of restorative dentistry at the University of Edinburgh and Director of Edinburgh Dental Institute in Scotland and a consultant in restorative dentistry to NHS Lothian. He directs the NHS Lothian Oral Health Service. He has been a member of the UK Government's Scientific Committee on Nutrition for 10 years, in this role he was instrumental in changing the UK's governments' policies so that the current recommendation is that free sugars intake should be no more than 5 per cent of dietary energy intake, this was adopted in 2015 and the UK's Governments were the first to accept this recommendation as policy in accord with the recommendations of both the WHO and SACN. His clinical and research interests focus on the oral health challenges and needs of the older person, particularly in relation to increasing frailty and the common risk factors for oral and systemic diseases including sugars.

Pay report released

Long-awaited report from remuneration body leads to potential disappointment for dental professionals

THE long-awaited report for 2018 from the Review Body on Doctors' and Dentists' Remuneration (DDRB) has been released. The primary recommendations relating to dentists in all four home nations are:

• A minimum 2 per cent increase to the national salary scales for salaried doctors and dentists across the UK

• For independent contractor GMPs and GDPs across the UK a minimum increase in pay, net of expenses, of 2 per cent.

The report, which was due to have been released in May – already running to a delayed timetable – was significantly further delayed due to the late submission of evidence from the Department of Health & Social Care and the Scottish and Welsh governments, with both the BDA and BMA raising concerns about this at the time. Ultimately this has meant that report has been released many months after the date at which any pay award would have been due.

So far, there has only been an announcement about how the recommendations will be applied in England. Although the Westminster Government has accepted the recommended 2 per cent increase, a departure from its usual policy of austerity, it has also announced that the uplift will not be backdated. Instead, it is being postponed to October to cut costs, a full six months after any uplift would normally be due. This effectively equates to a 1 per cent increase over the year – not quite the recommended 2 per cent. In addition, the Government is also proposing an uplift for expenses for general dental practice of 3 per cent (except for staffing costs, which will be limited to 2 per cent). This is also a departure in principle from the DDRB recommendations, which would have been 4.1 per cent and 3.2 per cent respectively had the cited formula been used.

At time of going to press, the Scottish Government had made no announcement about how it will respond to the recommendations, and the dental community are waiting to see whether similar restrictions will be put in place. This is particularly pertinent as, of course, the recent Agenda for Change pay increases announced for Scotland do not apply to those working in dentistry.

Dentists not included in visa exemption

THE UK Home Office has confirmed that doctors and nurses are to be excluded from the cap on visas for skilled workers, but not dentists or DCPs.

This means there are no restrictions on the number of doctors and nurses that can be recruited through the Tier 2 visa route, but the problem of recruiting non-EU dentists remains acute.

The Tier 2 visa has had an annual cap of 20,700 since 2011, but has recently seen the number of applications exceed the monthly allocation. This has been driven mostly by demand from the NHS, which accounts for about 40 per cent of all Tier 2 places.

Home Secretary Sajid Javid said: "I recognise the pressures faced by the NHS and other sectors in recent months. Doctors and nurses play a vital role in society and at this time we need more in the UK. That is why I have reviewed our skilled worker visa route."

The Home Office said its decision will free up hundreds of additional places for other highly skilled occupations, such as engineers, IT professionals and teachers – but dentists were noticeable by their absence from that list.

ARF stays unchanged for 2019

THE General Dental Council (GDC) announced in July that the annual retention fee (ARF) will remain unchanged for 2019.

The regulator said that in reaching its decision it had "weighed the complex picture of eternal risk it faces at a time when significant investment is being made for long-term improvement" and concluded "the time is not right to make the reduction it had hoped to".

GDC Chief Executive Ian Brack said: "As the GDC's accounting officer, it is my responsibility to ensure that the finance and systems of the GDC are robust and to highlight significant risks to the Council. We have made some significant progress in terms of real improvements and efficiencies over the last few years, but the combination of external risks facing the GDC for the coming year and the short-term cost of internal investment we're making to deliver 'Shifting the balance' and bring further long-term savings led me to advise Council against a reduction in ARF for the next year."

In early 2018, the GDC consulted on a new policy for its approach to settling fees and, in doing so, established the intention to base future consultations relating to fee-level on a three-year corporate strategy, costed at programme level. This consultation is set to take place in the first half of 2019.

Ian Brack added: "I really hope to hear as many views as possible and look forward to the valuable debate that will undoubtedly bring."

> "IT IS MY RESPONSIBILITY TO ENSURE THAT THE FINANCE AND SYSTEMS OF THE GDC ARE ROBUST"
>
> IAN BRACK

Questions remain around OHIP

Flagship plan leaves BDA asking for more information about implementation as dentists voice deep concern

SCOTLAND'S dentists have deep concerns about implementation of the government's Oral Health Improvement Plan (OHIP) given the absence of new investment to make the plan a reality.

This has led to BDA Scotland asking the Scottish Government to give more clarity and detail.

A recent survey showed that dentists questioned the possibility of meaningful reform without extra government funding.

Noting that morale among the dental profession is at an all-time low, BDA Scotland said it agrees with the principles at the heart of the plan, but the lack of detail on vital issues including funding and timescales, as well as lack of involvement from the profession in implementation, could put NHS services at risk.

BDA Scottish Council Chair Robert Donald said: "Talk from government on prevention and tackling health inequalities is long overdue, but will remain warm words until they are backed up with needed investment.

"Vulnerable older patients deserve oral health care tailored to their needs, but this plan fails to spell out how it can be provided safely and effectively, or how it will be paid for. Sadly, while officials have sketched out the big issues, they have skimped on the detail.

"This service has been hammered by years of austerity, flat-lining morale and political indifference. NHS dentists have led the calls for a plan, but now aspirations must be matched with real commitment from ministers, and a willingness to involve practitioners in the process."

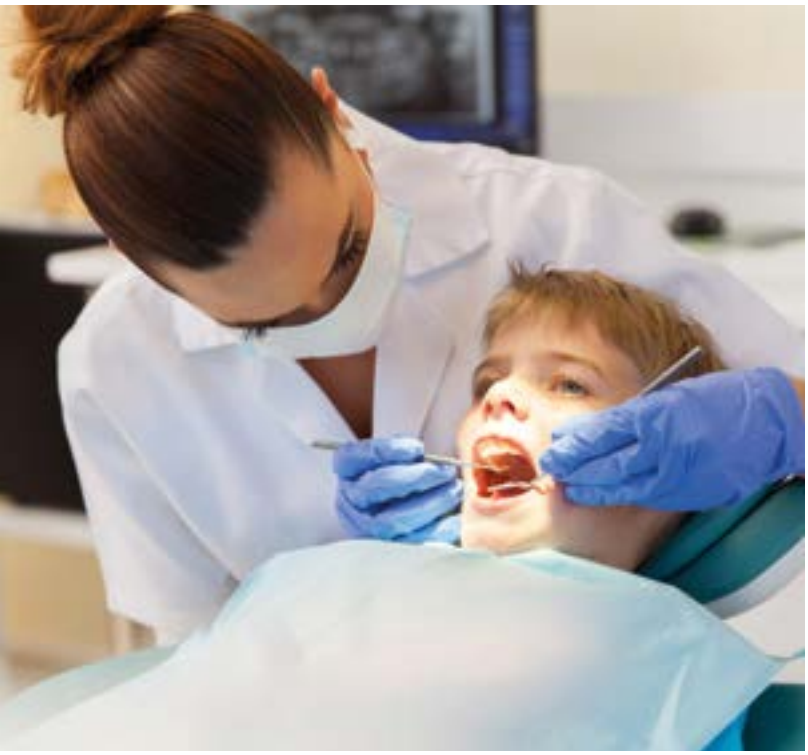
In response, Chief Dental Officer Margie Taylor said: "Our Oral Health Improvement Plan heralds a new approach to addressing the problem of oral disease through prevention for the whole population and includes several positive developments for dentists and their teams.

"We take the issue of morale very seriously. In association with the British Dental Association, we have developed new guidance to address concerns over disciplinary processes and look forward to helping practitioners maintain a high quality of service. We have also introduced a Scotland-wide occupational health service for dental practitioners and their teams.

"The BDA have also been involved in our discussions about how to address the needs of our older population. To ensure that dentists can be confident when providing domiciliary care, we have planned a training programme with a view to rolling out a new care service.

Chief Dental Officer Margie Taylor

"We share dentists' concerns about inequalities. The plan also contains proposals for a new Community Challenge Fund of up to £500,000 which will allow third-sector organisations to bid for funds to support families in deprived areas in an effort to change behaviours towards oral health."



New guide for dental caries in children

The Scottish Dental Clinical Effectiveness Programme has published a second edition of its Prevention and Management of Dental Caries in Children guidance.

The guidance aims to help dental teams improve and maintain the oral health of younger patients through preventive care and, where necessary, effective management of dental caries.

This second edition includes advice on:

› Assessment of the child and family
› Helping the family manage dental care
› Delivery of preventive care based on caries risk
› Choosing from the range of caries management options available
› Delivery of restorative care, including how to carry out specific treatments
› Referral and recall
› Management of suspected dental neglect
› Working with other agencies to support and safeguard the wellbeing of children and young people.

NICE (The National Institute for Health and Care Excellence) has accredited the process used by SCDEP in developing the guide. Furthermore, it is endorsed by several of the dental faculties of the Royal Colleges, the British Society of Paediatric Dentistry and Childsmile.

Associates in a grey area

The legal outcomes of the high-profile Uber and Pimlico Plumbers cases have failed to provide clarity on the self-employed status of associate dentists, who still face case-by-case determination

DESPITE recent high-profile cases in other sectors, the employment status of dental associates would still be decided on a case-by-case basis, according to an employment law specialist.

It is usual for dental associates to be classed as self-employed. Recently, that has been questioned, not least by HMRC, which has written to several associates to tell them that their status is under review. They could be re-classified as "employees" or "workers" – distinct categories in employment law (although for tax purposes, the category of worker does not exist).

The UK Supreme Court recently ruled in a case involving Pimlico Plumbers. It decided that Gary Smith, an individual who carried out work for the company, was a worker and not a self-employed contractor.

However, that finding does not necessarily provide further clarity to the case of associate dentists, according to Amy Jones, an employment law specialist at Thorntons Law.

"Any decision on employment status will still depend on the circumstances of each case," she said. "These cases are very fact dependent and there is still no clear guidance from the courts."

She explained that cases such as Pimlico Plumbers, and that taken up by a driver at Uber, were judged according to specific factors. The Pimlico case focused on features including personal service and Mr Smith's contract, which imposed a limited right to provide a substitute to carry out the work allocated to him.

In the Uber case, there was a focus on "control". Uber decided the routes drivers should take, and the company, rather than the driver, dealt with any complaints – the levels of control exercised by the firm went beyond what you would expect in a self-employed situation.

Both situations contrasted with the normal circumstances found in dental associate arrangements. For example, associates are usually expected to provide a substitute (locum), or cover the cost of providing one, if they are to be absent for an agreed period of time.

> "IT IS USUAL FOR DENTAL ASSOCIATES TO BE CLASSED AS SELF-EMPLOYED. RECENTLY THAT HAS BEEN QUESTIONED"

Similarly, individual associates would traditionally be expected to deal directly with complaints. However, as Amy said, "in a group practice scenario if they didn't respond individually but were governed by guidelines set out by the practice it might be argued they are not self employed".

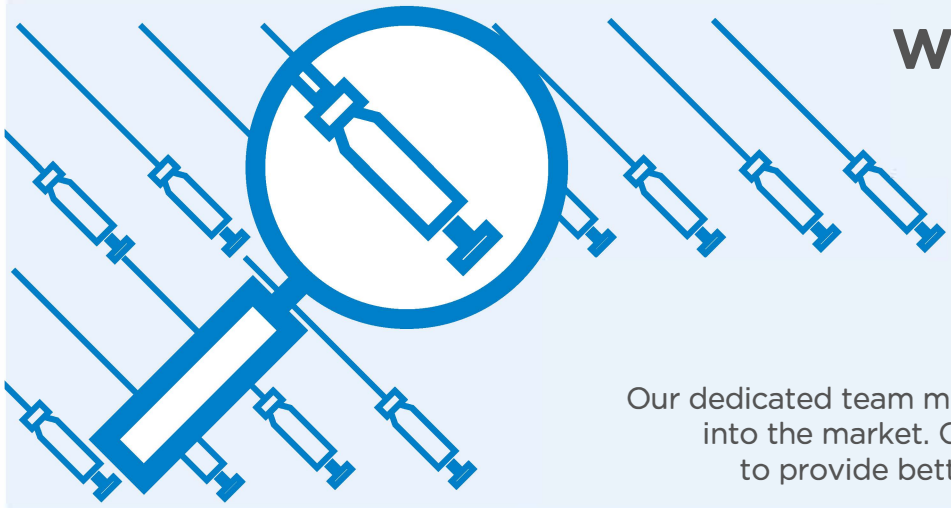
Other important factors she highlighted included the amount of commercial risk assumed by an individual, and their level of integration within the practice.

There is some hope that certainty on this issue will be forthcoming. "To date, there have been few challenges to associates' self-employed status. That may change, and the direction of the government is to try to clarify all of this," said Amy.

Until that point it seems this remains a frustratingly grey area.

Safety

YOU ARE ENDO, + WE KNOW ENDO.



WE CAREFULLY MONITOR EVERY FILE WE LAUNCH!

Our dedicated team monitors every file we launch into the market. Our mission is to enable you to provide better, safer, faster dental care.

WE GO OVER EACH AND EVERY PRODUCT CLAIM WITH A FINE-TOOTH COMB!

A full team of dedicated research engineers and specialists thoroughly test our products in order to validate all our claims, benefiting from state-of-the-art equipment in both our Johnson City and Ballaigues facilities.

WE WORK IN COMPLIANCE WITH THE HIGHEST STANDARDS OF SAFETY

We are certified and accredited by top regulation authorities worldwide:

- ISO 13485 Certficate BSI - MD 670384
- EC Certficate BSI - CE 670383
- ISO Certificate 9001
- ISO Certificate 14001
- ISO 13485 Certficate Tulsa
- 2006 FDA Registration
- 2015 Maillefer FDA Registration
- EC Certficate BSI - Full Quality Assurance system
- Japanese Accreditation

THE DENTAL SOLUTIONS COMPANY™

Dentsply Sirona

HPV programme for boys welcomed

Success for high-profile campaign to extend vaccinations

THE decision by the Scottish Government to introduce a human papillomavirus (HPV) vaccine programme for adolescent boys has been welcomed by the Scottish council of the British Dental Association.

When announcing the government's move in mid-July, Public Health Minister Joe FitzPatrick (pictured) said: "The Scottish Government will implement a HPV vaccination programme for adolescent boys in Scotland. We know from the recommendations made by the Joint Committee on Vaccination and Immunisation (JCVI) that this will help reduce diagnoses of HPV-related cancers and save lives in years to come.

"Work to develop the programme will now begin, in conjunction with Health Protection Scotland and NHS Scotland, to be rolled out as soon as is practicable."

The BDA's Scottish Council applauded that swift commitment. David Cross, its vice chair, said: "Oral cancer rates in Scotland are double

those in England, and people from our most deprived communities are up to three times more likely to be affected. HPV is a key risk factor, and this year 30,000 boys in Scotland have gone unprotected. We applaud the fact ministers have shown real commitment and pledged to give boys the same protection our girls currently receive through the school vaccination programme.

"Oral cancer claims more lives in Scotland than car accidents. Dentists are often the first to spot the condition and have fought to see the logic of prevention put into practice.

"We need the Scottish government to work with the profession to turn the tables on this life-threatening condition."

Changes for trainees

EMPLOYMENT arrangements for Scotland's dentists in training and junior doctors are to be simplified.

As part of their training, dentists and junior doctors can move around some of Scotland's 22 health boards. Until now, each time they move they have to change employer. This is time-consuming and can cause problems for things such as mortgages, tax codes, and access to employee service-based schemes.

Under the new arrangements, trainees will carry on working where they are, but for administrative purposes the 22 Health Board employers are being reduced to four, with trainees having one employer for the duration of their training programme.

Initially, this will apply to junior doctors, but will later include dentists in training.

New Dean for Faculty of General Dental Practice

IAN MILLS has been inaugurated as the new dean of The Faculty of General Dental Practice (UK). Ian, pictured above, second from left, with the full GDPUK board, qualified from the University of Glasgow in 1987 and now works in general dental practice in North Devon. He previously held the post of Academic Clinical Fellow at Plymouth University Peninsula School of Dentistry, and is a Fellow of the Faculty. Ian is also a Fellow of the Higher Education Academy and the Faculty of Dental Surgery of the Royal College of Physicians and Surgeons of Glasgow.

Ian spent the early part of his career working in maxillofacial surgery. In 1994 he moved to Devon and three years later set up Torrington Dental Practice, a mixed practice, where he continues as a partner.

The Faculty also has two new vice-deans – Mark Richardson and Onkar Dhanoya. Mark is group captain in the RAF and the chief dental officer. He is also the armed forces clinical adviser on paedodontic dentistry and a Fellow of the Faculty of Dental Surgery of the Royal College of Physicians and Surgeons of Glasgow. Onkar, a Newcastle University graduate, has been principal dentist at Honour Health since 1986.

4 - 6 October 2018
ExCeL, London

dentalshowcase.com @dentalshowcase #BDIAdental18

Platinum Sponsor

Oral-B

Gold Sponsor

Colgate

Media Partners

The Dentist DentalUpdate Dental Nursing

BDIA DENTAL SHOWCASE
Putting innovation into practice

BA Chief Training Pilot Steve Hawkins

What has aviation got to do with dentistry?

A lesson from the cockpit about their similarities in terms of risk and regulation shows that it is important to learn from other professions

DENTAL professionals are being challenged to learn not only from their peers, but also those outside of the industry. In a captivating lecture at the BDIA Dental Showcase in October, entitled "Lessons from the Cockpit", Steve Hawkins, BA's Chief Training Pilot, will compare aviation and dentistry.

Surprisingly there are many similarities. Risk is inherent in both – for the provider (pilot/dental professional) and the customer (passenger/patient).

Similarly, dentistry and aviation are overseen by regulatory bodies, who set the standards, risk management, training and ongoing assessment of competence. Safety is key to both industries. However, Steve will explore how attitudes to the reporting cultures of the two industries may differ.

The aviation industry actively encourages mistakes to be reported, without fear of recrimination. It needs to do this to make flying safer and sees such a culture as intrinsic to "proactive safety management"; an open feedback loop must be created to enable changes to be implemented.

Readers will be all too familiar with the growing number of cases brought against dentists by the General Dental Council. Clearly there is some disparity between the open reporting culture of the airline industry and the sometimes "closed loop logic" of healthcare.

Steve's insightful lecture will deliver real knowledge that can be applied within practice. His lecture promises to make you step back and question yourself and your 'business' (even though some professionals may find such a description anathema). Pilots must be honest about both their strengths and their weaknesses, and failure should be embraced, if it initiates changes to routines and practices. It has been a game changer within aviation and could also be within healthcare in general.

Steve will be just one of the speakers assembled as part of the Dental Update Study day at the event in London on 4 October, hosted by Professor Trevor Burke, who will be giving a lecture entitled "Minimising Failure with Direct Restorations and Crowns". John Milne, Head of the CQC, will also present a potentially contentious session on regulatory matters, while Professor Tara Renton will look at specific risks associated with oral surgery.

> "THE AVIATION INDUSTRY ACTIVELY ENCOURAGES MISTAKES TO BE REPORTED, WITHOUT FEAR OF RECRIMINATION"

A full programme of lectures continues through Friday and Saturday, with a wide range of presentations.

Insight into oral health habits

ADULTS in the UK spend almost £200 a year on oral health care products, according to a recent survey. And they want the government to follow their lead by providing greater funding for NHS dentistry.

An investigation by the Oral Health Foundation showed that the average monthly spend on products such as toothpaste, mouthwash, interdental brushes and sugar-free chewing gum is £16.34.

In Scotland, people living in Edinburgh spend most every month (£14.22) followed by Aberdeen (£12.81) and Glasgow (£9.00). The UK's highest expenditure is in London where people spend an average of £25.53.

Meanwhile, new research, undertaken as part of National Smile Month, reveals strong public support for more NHS dentistry funding; with 48 per cent of British adults saying they would be willing to pay more National Insurance to improve services.

Dr Nigel Carter, chief executive of the Oral Health Foundation, welcomed people's willingness to invest in oral health, but warned against any attempts to increase the financial burden on patients. He said: "A healthy mouth often translates to a healthy body, and this message is being adopted by greater numbers of a population which is becoming significantly more health-conscious.

"Dentistry currently receives a very tiny amount of the NHS budget but still offers a service of exceptionally high quality.

"NHS dental charges for patients have recently increased by 5 per cent, almost twice inflation, which means patients are having to make up the shortfall from government funding. This has to stop, and it is time the government make changes which do not put pressure on patients."

1. Oral Health Foundation (2018) 'National Smile Month 2018 United Kingdom Survey', Atomik Research, Survey, April 2018, Sample 2,005

A FRESH APPROACH TO DENTAL DESIGN

Concept Design | Space Planning | Detail Design | Planning Applications | Building Warrants | Construction Detailing | Project Management |

Interior environments have considerable impact on their users, be that staff or visitors, and thoughtful, imaginative design can make all the difference. Lighting, colour, texture and layout can work to provide a positive experience, which for a dental practice is an important aspect of patient care.

VisionCall Dental, Lanark

0845 548 9860
www.nvdc-dental.co.uk
enquiries@nvdc.co.uk

NVDC ARCHITECTS

PEOPLE NEWS

Stonehaven hygienist raises a smile

Dental hygienist Trish Maitland from Stonehaven was named as a winner of Nominate A Smile, a UK-wide search to find dental professionals who deserve recognition for their impact in the community.

Based at Dental Inspirations in the town, she was chosen for the award for her commitment to NHS dentistry, charity and voluntary work.

Describing Trish, her practice manager Leianna Minty said: "Nothing is too much for her, she goes above and beyond for all her patients and really just anyone she comes into contact with."

Trish also provides care for her son who has cystic fibrosis and takes time to raise money for charities.

The Nominate a Smile competition was part of National Smile Month.

Students recognised for work in community

A group of students at the University of Dundee School of Dentistry have received recognition for work they did on a community oral health project.

Fourth-year dental students were asked to select an area or group of the community and raise awareness of oral health by showing them how to develop good oral health routines.

The students worked with voluntary and community organisations to help them reach out to individuals with mental health issues, the homeless and those with learning disabilities.

The winning group worked with autistic children and created a storyboard explaining the process of visiting the dentist.

Aberdeen student wins prestigious award

Stephanie Wilson BSc (Hons) BDS, a graduate of Aberdeen Dental School, has been named as one of this year's winners of the Royal College of Physicians and Surgeons of Glasgow's UK Dental Undergraduate Award.

Stephanie studied Immunology and Pharmacology at the University of Strathclyde Glasgow (2009 – 2013), before embarking on a degree in dentistry at the University of Aberdeen (2014 – 2018). She is about to start a VDP post at Woodside Dental Practice in Aberdeen.

In all, three successful applicants received a prize of £500 in the awards. The other winners were Ryan Major of Newcastle Dental School and Luke Savva of the University of Central Lancashire.

Professor Graham Ogden, Vice President (Dental) of the Royal College of Physicians and Surgeons, said: "As the UK's only multidisciplinary Royal Medical College, we're delighted to be able to recognise and support the emerging talent in dentistry from across the UK."

You didn't spend years training as a dentist to become an administrator

Running a practice is more than a full-time job. It's several jobs.

You have to be a marketing manager, a teacher, even an administrator. Which can leave precious little time for being a dentist.

Simplyhealth Professionals can give you that time back.

With our new online tool, patients' payment plan details update in real time. Giving you up-to-the-minute data and insight about the patients in your practice. No more waiting for monthly reports to arrive.

Making life easier for everyone.

Get back to being a dentist not an administrator.
Call one of our Consultants today on
0800 169 9962 or visit **denplan.co.uk/plans**

Denplan from Simplyhealth Professionals

CAM2615 06-18

Simplyhealth Professionals, Simplyhealth House, Victoria Road, Winchester, SO23 7RG, UK. Tel: +44 (0) 1962 828 000. Fax: +44 (0) 1962 840 846.
Simplyhealth Professionals is a trading name of Denplan Limited, registered in England No. 1981238, registered office Hambleden House, Waterloo Court, Andover, Hampshire SP10 1LQ.

DATES FOR YOUR DIARY

4 SEPTEMBER
Practical advice for new consultants
Royal College of Physicians and Surgeons of Glasgow* (RCPSG)

5 SEPTEMBER
The emergency dental patient
RCPSG

5-8 SEPTEMBER
World Dental Congress
Buenos Aires
More information at: www.fdiworlddental.org/events/fdi-world-dental-congress

7 SEPTEMBER
BDA Scottish Dental Conference and Exhibition***
Crowne Plaza, Glasgow

11-14 SEPTEMBER
British Society of Paediatric Dentistry Annual Scientific Meeting
Caird Hall, Dundee
More information at: www.bspdconference.org

17 SEPTEMBER (AND 22 OCTOBER)
Royal College Advanced Certificate in Clinical Education
Glasgow
RCPSG*

20 SEPTEMBER
Royal College Advanced Certificate in Clinical Education
Heathrow
RCPSG*

27-29 SEPTEMBER
British Orthodontic Conference
Queen Elizabeth II Conference Centre, London
More information at: www.bos.org.uk

30 SEPTEMBER - 2 OCTOBER
The Infection Prevention Show
Scottish Event Campus, Glasgow
More information at: www.ips.uk.net/conference

4- 6 OCTOBER
BDIA Dental Showcase
ExCel, London
More information at: www.dentalshowcase.com

8 OCTOBER
BDA Aberdeen Section – Children and young people: Management of traumatic dental issues
Doubletree Hilton Treetops, Aberdeen

12 OCTOBER
CBCT Training for dentists (two-day course)
Royal College of Surgeons in Ireland (RCSi)#
Dublin

19 OCTOBER
Management of Medical Emergencies in Dental Practice (Simulator course)
Dublin
RCSi#

20 OCTOBER
Annual Scientific Meeting
Dublin
RCSi#

25 OCTOBER
BDA Member Series – A day on paediatric dentistry
Edinburgh

26 OCTOBER
The Faculty of Dental Surgery Annual Dinner
RCPSG*

1 NOVEMBER
Core Topic Study Day for DCPs
Royal College of Surgeons of Edinburgh** (RCSEd), Edinburgh

** More information for RPCSG events at: https://rcpsg.ac.uk/events*

***More information for RCSEd events at: www.rcsed.ac.uk/events-courses*

****More information for BDA events at: www.bda.org/events*

 # More information for RCSi events at: http://facultyofdentistry.ie/postgraduate-programme/upcoming-events

> Protection > Support > Expertise

Today's the day... Little Sister puts you in the picture.

Creating a compliant decontamination process is a little like painting a masterpiece, it can be seem a daunting challenge rather than a labour of love.

Just as the artist decides how to apply light and shadow, colour and texture, there are many facets of an effective decontamination process that need to be considered before you can be sure you have got something that is fit for purpose and complys fully with the rules you have to follow.

To see how Little Sister can help put you in the picture today, call EschmannDirect on...

01903 875 787

www.eschmanndirect.com

Lifetime Breakdown Protection

CARE& COVER

SES 3000B
B type vacuum
£3,790
(rrp £4,190)

Prices shown are valid to 31st August 2018 and excl. shipping and VAT

LITTLE sister
SES 3000B
The UK's Leading Vacuum Autoclave

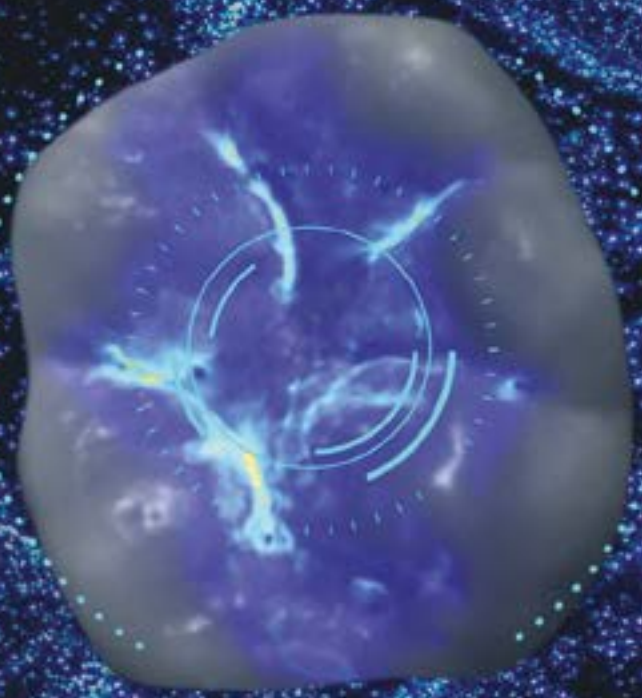
ESCHMANN DIRECT

Please contact us now at
demo.calcivis.com
to arrange your
in-surgery
demo.

EUROPEAN PRODUCT DESIGN AWARD

AWARDS 2018
WINNER

Dental Industry Awards
Winner
Innovation of the Year



Harnessing the power of bioluminescence to visualise active demineralisation.

The CALCIVIS imaging system is a unique device which enables real-time visualisation of early demineralisation. At its heart is a unique biologic photoprotein, similar to those used by many marine lifeforms to naturally generate visual signals, which reacts directly with the calcium ions released in early stages of demineralisation. The photoprotein creates a vivid bioluminescence providing visual evidence of early signs of caries and erosion. In doing so, the CALCIVIS imaging system enables you to effectively demonstrate to your patients a rationale for undertaking a minimally invasive approach, safe in the knowledge that you are treating dental decay at the earliest possible opportunity.

FIND OUT MORE AT **CALCIVIS.COM** OR CALL **0131 658 5152**

CALCIVIS imaging system starter pack: *(includes imaging device and photoprotein for up to 20 patient exams)* STPK01 Recommended Purchase price: £1,500 (ex.VAT)

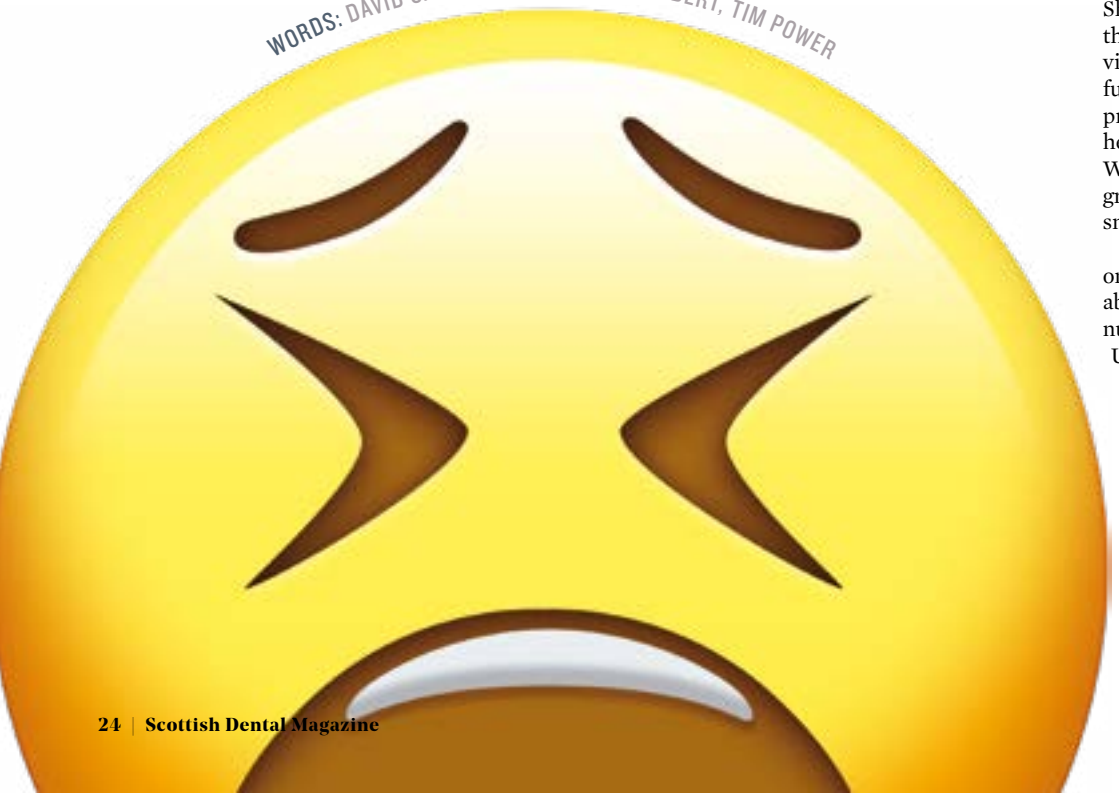
CALCiViS®
dental enlightenment

MENTAL HEALTH

Dentists in distress

Being a dentist has never been tougher. And it's taking a serious toll. Burnout, anxiety, depression...worse. Scottish Dental doesn't have the answers, only signposts to help. The journey starts here

WORDS: DAVID CAMERON, STEWART McROBERT, TIM POWER



When the envelope arrived from the GDC outlining the complaint, anxiety instantly constricted her chest. She felt slightly faint. But, after the third read, she felt balance returning. Wasn't she certain she had done nothing wrong? Wasn't the complainant being as unreasonable now as he had been when he was in her practice?

Ten months later, an intense inquiry was under way. But not just into the original allegation. The GDC probes were delving deep into other unrelated case files that had been requested. And with it, she had morphed from a competent, confident clinician into a nervous wreck, frantic about her professional future and the security of her young family. Until the morning of the breakdown, her husband had thought she was "simply" stressed, going through the type of difficult time that so many professionals face at some point in their careers. But when he found her weeping in the bedroom, unable to get dressed to go to work, their world almost collapsed.

The story is true but the dentist for whom this was a reality doesn't want the world to know her name. She fears that what she went through would even now, despite vindication before the GDC and a full health recovery, damage her professional reputation in the eyes of her contemporaries and her patients. Worse, it could still put an even greater strain on the viability of her small rural practice.

The reality is that this is not one isolated, extreme case. It is absolutely typical of the increasing numbers of dentists all over the UK who are suffering in silence, some of whom do not make the recovery that the practitioner in our study was able to make. Some are forced to quit the profession forever because they just cannot take the strain.

Suicide is a reality in our society, particularly in some areas of the UK such as Northern Ireland and parts of Scotland, and tragically, in

recent years, several dentists who have felt overwhelmed have taken their own lives.

However, with wider recognition and public understanding of mental health issues, momentum is now growing within the dental profession for the radical change that is needed to tackle an insidious problem that is blighting the lives of so many professionals across the UK and the Republic of Ireland.

Scottish Dental magazine is committed to playing its part in supporting this work. Our aim is not to provide answers or solutions for individuals. Our key objective is to strive continuously to raise awareness of the issue and to provide, where possible, vital signposts for dentists to reach the professional support they need to help deal with the mental health issues they are facing.

We will be talking to the psychologists who are providing their expert help daily to professionals in difficulty, the organisations that are coming together to work towards a new way of helping those in trouble, and reporting on the stories that are impacting on this area of deep concern.

Passionate campaigner

Roz McMullan is currently chair of the BDA's Northern Ireland Council and BDA President-Elect (2019/20), and she is a passionate campaigner on the issue of mental health among dentists. She has always been aware that stress was an issue for many of her colleagues, but the point at which she knew she had to act personally was when dentists and their families in Northern Ireland were struck by tragedy on a number of occasions. Not all of these were directly related to dental issues being faced by those who took their own lives but a number were. Enough was enough; something had to be done.

In Northern Ireland, Roz and her colleagues are now working within a framework that not only addresses the issue but also has an element through which outcomes can be measured. At its core is Probing Stress in Dentistry, a joint working group with representation from the BDA, the Deanery (Northern Ireland Medical and Dental Training Agency), the Northern Ireland Public Health Agency, the BDA Benevolent Fund and indemnity organisations. Recently, it has been powerful in producing guidelines on how to tackle the issue of mental health.

Roz McMullan, Chair of the BDA Northern Ireland Council

It has developed a range of access points through which dentists can get the help they need. It has created seminars and courses that they can attend to learn more about the problems and how to deal with them. It even has a small "roadshow" stand that is taken to events to raise awareness and offer guidance.

"We have to tap into the professional help that is out there and not try to be a panacea. We need to be signposts, guiding people to the proper help that they need. Access to occupational health services for dentists has been a great step forward in Northern Ireland," said Roz.

"We see our role not in offering solutions for individuals. This is absolutely a job for the professionals. Our place is to offer to support and to raise awareness. We are bringing in the experts to help. And we are showing our colleagues where they can go to find the professional help they need," she explained. "We are also continuing to work with other stakeholders to improve timely access to professional help when dentists need it."

A measure of the success of this approach is the fact that the courses that are run by Probing Stress in Dentistry are always fully subscribed. "We see it all the time and that tells you just how big an issue this is and how important it is that we make this information available to all."

Turning to the nature of the problem, Roz highlights a number of key issues facing dentists around the country. Stigma is a big one.

"There is an issue of people not being prepared to put their hands up. They fear the real and perceived consequences of doing so. They are frightened of the increased risk of complaints, possible loss of income, loss of face, impact on their families and their colleagues. There are a lot of pressure points," she said.

Another is money. Making a decent living in dentistry can be a very tough challenge. The reality is so different from much of the public's perception. And so, regardless of how difficult or stressful the job has become, many, many practitioners are self-employed and simply cannot afford to take time off. The result can be perceived as devastatingly simple: No work, no income. No income, no future. No future, no life.

"I'm not certain what the answer is, but I feel that we have to be working towards some form of practical help for people running practices who are feeling overwhelmed and are needing to take time off. Health boards need to be taking more responsibility here and helping to find answers. The NHS needs to value its workforce."

And for many, the trigger is the ever-increasing burden of regulation and governance.

"It's incumbent on everyone in leadership not to burden healthcare workers with more issues that provide more stress. There needs to be right-touch regulation. We can't keep increasing pressure on people with more and more regulation.

"Recently I was talking to a very experienced dentist who had a complaint against him through a solicitor. When the reports were gathered, the solicitor said he felt that there were potentially no grounds for legal action. But, he suggested, the patient could, if they wished to continue to seek redress, pursue the matter through the GDC. And indeed this is what the complainant has done. The onus is on the GDC to make sure their responses are proportionate," she said.

"HEALTH BOARDS NEED TO TAKE MORE RESPONSIBILITY. THE NHS NEEDS TO VALUE ITS WORKFORCE"

ROZ McMULLAN

Roz McMullan believes that we are moving forward in tackling the problem, just perhaps not fast enough. She hopes that when the results of a major new study by the BDA and the University of Cardiff – about 2,000 dentists have been surveyed on the trigger points for their stress levels – are published, this important piece of work could be the springboard for greater action.

"We now know how many people are suffering so we know this is a very real problem and not just people talking. Soon, through the work that is being done, we will have the data that we need to identify the key triggers. This is crucial in taking us forward.

"Will we ever be able to prevent these issues? No. But could we help people to manage things better, I am absolutely certain that we could."

Breathing Space

In Scotland, a considerable amount of work is under way and once again, the advice from within the dental profession is to seek professional help at all times.

North of the border there are numerous bodies and organisations that specialise in helping deal with specific problems and issues. But it can often be hard to work out which one would be best to help deal with a particular issue.

The Scottish Government became so concerned about the mental health of the population, including that of the medical and dental professions, that in 2002 they set up the Breathing Space telephone service as a 'first port of call' for people in distress. Today, this confidential call service, staffed by a range of experienced professionals, handles 8,000 calls a month. It is an excellent, highly professional start point for anyone needing help.

Lisa-Jane Aitken is Breathing Space's National Development Officer and has a background in developing suicide-prevention initiatives. She said: "We handle calls from people that are just having a stressful day, maybe because they have had an argument with a family member, right through to those in real distress.

"We have a wide range of expertise available and our job is to listen to the caller and, through open-ended conversations, allow people to work through whatever it is that they are experiencing at that moment.

"Our other role is to signpost them to local organisations or national resources that can support them with their particular issues."

> "WE ARE HEARING THAT A LOT OF PEOPLE ARE FEELING VERY ALONE DESPITE HAVING A LOT OF PEOPLE AROUND THEM"
>
> LISA-JANE AITKEN

The largest number of issues that Breathing Space deals with are the consequences of relationship breakdowns. However, loneliness and isolation are also highly significant. For dental professionals, particularly those working in single-handed or rural practices, this sense of isolation, accentuated in times of stress, can be particularly damaging.

According to the latest statistics on suicide in Scotland, of the 680 people that took their lives in 2017, 552 were men. Research shows that men are more at risk of mental health problems as a result of relationship breakdowns because they are often the ones that will lose their home, become estranged from their families and not be able to see their children. This, ultimately, has an impact on their performance at work, and as they can't often talk about their personal situation at work they can enter a spiral of despair, which can lead to them considering suicide.

The growing trend in people calling Breathing Space with loneliness and isolation issues is also alarming, as Lisa-Jane explained: "You would think this only applies to an older generation that might not have any family to support them, but what we are actually hearing is that a lot of people are feeling very alone despite having a lot of people around about them.

"For me, it's so important that people in crisis talk to someone about what's going on in their life. By doing this they will soon realise that they are not alone and by opening up and talking about how they feel will ultimately make them feel better, even if it is just in that moment. After that they can look for support and learn strategies to make them more resilient and improve their mental health."

If you are feeling overwhelmed and unable to cope, for more information:

SANE
Web: www.sane.org.uk
Phone: 0300 304 7000

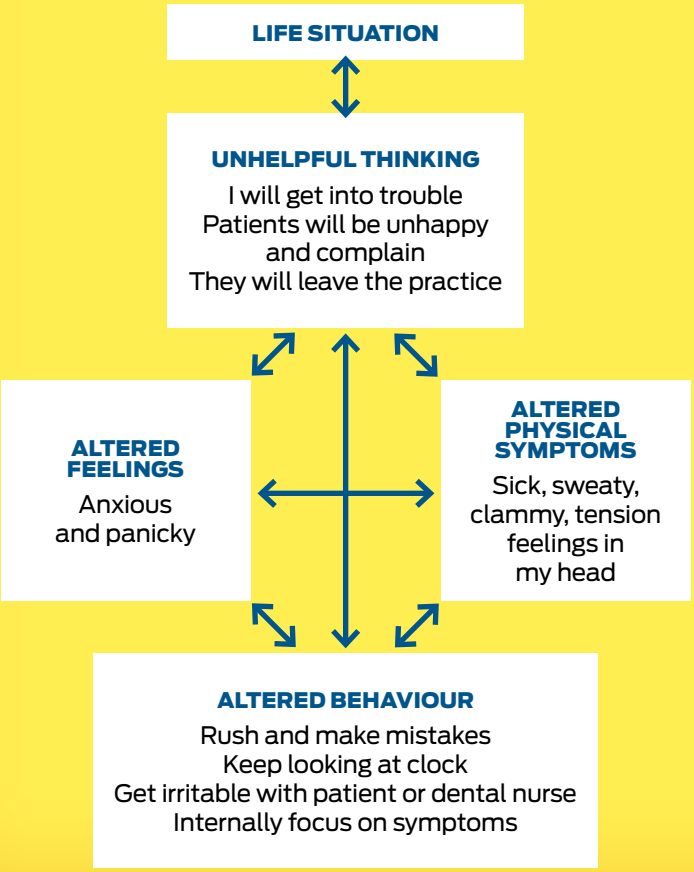
Breathing Space
Web: www.breathingspace.scot
Phone: 0800 83 85 87

Samaritans
Web: www.samaritans.org
Phone: 116 123 (UK)
116 123 (ROI)

BDA
Web: www.bda.org
Phone: 01786 476040

ANXIETY, GOOD AND BAD

Barbara Gerber explains how a necessary human response can get out of control



Worries, fears and anxieties affect us all; most of the time, our responses to these are reasonable as well as being necessary for survival. In avoiding talking about or acknowledging that we are struggling with anxiety, we become increasingly more anxious. The purpose of anxiety is to warn us of danger, and to equip us to deal with it and allow us to remain alert until the threat has passed. Therefore, it is a crucial aspect of everyday living. We all need a certain amount of anxiety in order to focus the mind and to help to motivate and protect us.

Imagine you are crossing a busy road and you suddenly notice that a car is speeding towards you. You realise the danger, and jump out of the way.

In the example above, a series of physical, mental, and behavioural changes take place, which leads to the **flight, fight or freeze-startle response.** This is seen throughout the animal kingdom. The adrenaline hormone and the involuntary nervous system send signals to various parts of the body, enabling it to respond immediately. This is self-preservation in action. When the danger has passed, the changes subside.

The problem arises when the brain misinterprets a situation as being dangerous when in fact it is not; it starts the fight, flight, freeze response which results in a body full of energy raring to go, but with few outlets.

When we become over-anxious, worried, or stressed, this interferes with our ability to think clearly and act in a measured way.

Sometimes anxiety can be ongoing, lasting months, even years. Experiencing a number of stresses in our life and becoming preoccupied with worry can result in our everyday level of anxiety gradually increasing. Such long-term anxiety can result in exhaustion, being easily startled, irritability, having difficulty concentrating and can lead to bowel and sleep difficulties, leaving us feeling overwhelmed and low.

BARBARA GERBER

Barbara Gerber has a BSc and a BA Hons in psychology as well as a diploma in CBT. She set up Equilibria psychotherapy clinic in 2010 along with two colleagues, after having worked for many years at the Priory hospital in Glasgow. This clinic specialises in treating depression, anxiety, low self-esteem along with many other mental health issues

Impact on our lives

The impact of anxiety on us can be understood by considering the ways it affects different areas of our life. The Five Factor Model examines in detail five important aspects of our lives. These are:

- life situation, relationships and practical problems
- altered thinking
- altered feelings (or emotions or moods)
- altered physical symptoms in our body
- altered behaviour.

Our thoughts about a situation can affect our feelings or emotions, our physical wellbeing, and our behaviour. We can interrupt this vicious circle in a number of ways:

- understanding the body's response when anxious
- challenging your own unhelpful thinking patterns
- challenging your own behaviours.

The most common physical symptoms of anxiety include tight painful chest, difficulty and shortness of breath, palpitations, trembling, shaking, headaches, nausea, sweating, dry mouth, tight neck and shoulder muscles, tired eyes, difficulties in concentrating, memory lapses and fatigue and these tend to make us worry and often result in withdrawal into self, which in turn starts the vicious cycle. We often indulge in excesses, such as alcohol, food, recreational drugs and cigarettes, which make us feel better short term, but long term, increases anxiety.

What tools can we use to help?

- **To help with the physical symptoms** we can adopt diaphragmatic breathing. If we have been breathing erratically for some time, it can be difficult to switch from hyperventilating to controlled or diaphragmatic breathing. In order to practice this, imagine you have a balloon inside your stomach and when you breathe in, you imagine the air going down into your stomach and thus your stomach expands – when you breathe out imagine the balloon deflating and thus your stomach goes in. Take a normal size of breath, because if you breathe too deeply, you will feel light-headed. Breathe slowly and in a controlled manner. It is worth practising daily,

starting with lying down, then in a chair, then standing while in a relatively relaxed frame of mind. Being able to consciously change your breathing while anxious is an acquired skill and takes several weeks of practice, but if you are able to master this, you will find it reduces your anxiety within about 30-60 seconds. Alcohol, caffeine and excess sugar increase anxiety and impact on the quality of sleep you get, so try to reduce these; however, exercise and relaxation help to reduce anxiety, so try to increase these.

• **To help with our thought process:** The way we think can contribute to the maintenance of our level of anxiety. We not only think in verbal terms, but also in visual terms. Many people who experience anxiety problems overestimate danger and underestimate their own ability to cope, e.g. overestimating the problem presented by the patient, and underestimating their ability and skill as a dentist. We anticipate problems based on predicted, extreme outcomes rather than basing them on realistic evidence. One of the problems with anticipation is that the thoughts generated are often inaccurate and fail to relate to actual events. Dwelling on these potentially unpleasant events in detail is time-consuming, distressing, and interferes with daily functioning. Anticipatory worries start with 'What if...?' questions. We can also become hypervigilant, seeing danger in every situation. And finally we often hold a post-mortem on situations we have just encountered, ignoring all the positives and only focusing on any perceived negatives. In order to challenge these ways of thinking, we need to focus on the evidence of our own personal experience – thoughts are not facts. We need to look at the thoughts that are making us anxious, e.g. from the example above "I will get into trouble" and ask yourself – Is there evidence to back this up? Has this happened before? And the evidence against – How many times have I been late and not got into trouble? And then come up with a more realistic thought and act accordingly, e.g. "I have been late many times before and nothing bad has happened so I won't rush".

> "DWELLING ON POTENTIALLY UNPLEASANT EVENTS IN DETAIL IS TIME-CONSUMING AND DISTRESSING"
>
> BARBARA GERBER

• **To help to challenge behaviours.** The most important behaviour to challenge is avoidance – when we are anxious we often avoid facing up to whatever is anxiety provoking, e.g. not opening mail, not responding to emails, and not making "that phone call". This only increases your anxiety, so challenge yourself to do whatever you are avoiding.

Burnout, a menace that will only get worse unless there is change

The best academic literature on burnout from leading specialists around the world has been compiled and carefully analysed by the Medical Protection Society (MPS). It has used this work to inform and create workshops it now runs across the world to help medical professionals recognise and cope with burnout. Similar programmes for dentists are nearing completion.

In the vanguard of this work at MPS is Dr Suzy Jordache (pictured), Senior Medical Educator, who, along with her colleagues, is passionate about tackling a problem which she only sees getting worse unless change comes soon, particularly to the environments and circumstances in which doctors and dentists are working today.

Her focus has been on burnout, a phenomenon in its own right and not to be easily linked to, or confused with, the mental health issues of anxiety and depression. The evidence points to their being a significant difference, says Dr Jordache. And it lies in the fact that time away from the coalface can bring quick relief from the effects of burnout. It is, however, only a trained specialist who can tease out the difference and provide guidance on how to cope with either, or both.

In essence, she explains, the urgency for addressing burnout in the profession can be encapsulated in a simple equation: burnout = errors = complaints = claims.

"It's obviously a great deal more complicated than that but we are coming at the problem from the perspective of managing risk," she said.

As part of *Scottish Dental*'s drive to raise the profile of these issues, Dr Jordache will be writing in the next edition more fully on burnout, its causes, and what can be done to tackle it.

It's OK not to be OK

A welcoming smile or a simple "how are you today?" can be the start of creating a culture of mental health awareness in a dental practice, according to Lisa-Jane Aitken, Breathing Space's National Development Officer.

She said: "To support people's wellbeing it's important to create a culture where people know that it's OK not to be OK, and for colleagues to support each other through kindness and genuine concern.

"Very often, we can get consumed in our own busy day and lose the care and compassion that we should be displaying as human beings that encourages people to talk about things.

"We can do many simple things that can really help people's wellbeing on a day-to-day basis without doing anything radical. Practices could display mental health posters in the staff room or use mental health messages in regular staff meetings.

"It's all about removing the stigma around mental health and supporting people."

A problem shared...

The impact and continued growth of the Mental Dental forum on Facebook is an indication of the profession's concern over wellbeing

If any further confirmation were needed about the depth of the mental health problem facing the dental profession in the UK today, then surely Mental Dental – A Group For Dentists in Crisis has provided it.

The Facebook forum was set up by dentists worried that there wasn't enough being done to tackle the problem that many knew existed but were powerless to do anything to help to address.

Within weeks of being launched by Welsh dentist Lauren Harrhy almost 2,800 dentists had signed up. Today, that number has almost doubled and new members are being added every day. There are also 15 administrators and moderators, who are all dentists volunteering to help during their spare time.

The forum is a platform for fellow dentists to share their thoughts, fears and experiences. But it is imperative to stress that it is not a mental health resource, and there are concerns among some of the profession's leaders that the forum could exacerbate rather then help issues.

They strongly urge any dentist who is suffering stress or anxiety at work to contact their doctor or any one of the numerous professional mental health organisations and charities that exist to support people facing issues.

However, there can be no doubt that Mental Dental is a barometer of the depth of the problem. The number of members speaks volumes and, as one of its administrators argues, there is a place for it in the battle to tackle mental health in the profession.

Nicola McMillan is a Glasgow graduate who works as an associate in NHS general practice. She was installed as the first forum administrator after she and Lauren realised there were few places for dentists to go if they were feeling stressed or anxious.

She had known of dentists who had left the profession or, worse, taken their own lives, because of overwhelming pressures. Their shared concern led to Lauren setting up the group, despite the fact that she's a practice principal with three young children.

As the forum has developed, so has the ability of its members to help each other.

"The aim is to provide support but never to advise. We, and forum members, are fellow dentists not professional counsellors," she said.

She noted that certain topics crop up regularly – relationship issues between staff and principals, malicious complaints by patients, personal matters such as divorce, and general feelings of discontent with the profession.

One other area of concern is social media itself. "In our case, social media is a positive, but on many occasions it can help create or exacerbate negative feelings. We get lots of people suggesting that other forums where dentists' posts show them leading apparently idyllic lives simply serve to make fellow professionals feel depressed and/or insecure."

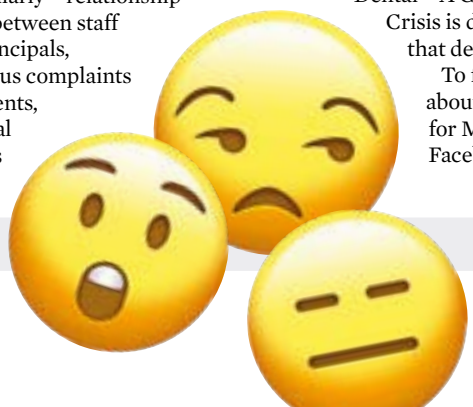
Notably, the forum has helped to demonstrate that fears about the mental health and wellbeing of dentists are not restricted to the UK.

A past president of the Australian Dental Association Queensland (ADAQ) was in touch with Lauren and Nicola in early 2018 to ask about their experience and how Mental Dental operates. As a result, that part of the world now has its own version called Mental Block. One of the main differences is that the Queensland forum is funded by ADAQ, unlike Mental Dental, which is fully self-supporting. Nicola believes there's a strong case for its own set-up to receive independent backing.

Meantime, the effectiveness of the forum can only be judged by its ability to provide support to its members. "We can never know for sure exactly what impact we are having," said Nicola. "However, we have had a lot of positive feedback and there's no doubt we have helped people – a number have taken the trouble to get in touch and say exactly that."

The need is out there, and Mental Dental – A Group For Dentists in Crisis is doing its bit to meet that demand.

To find out more about the group, search for Mental Dental on Facebook.



‘I felt guilty if I found a cavity’

Nicola McMillan describes herself as a proud Glaswegian, member of the GDP subcommittee of the LDC, indoor climber, Harry Potter fan and empathetic listener. Here, she tells the story of her own struggles with mental health in the hope of inspiring others to seek help

It started when I was studying for my Highers in fifth year. I was hyperventilating and felt I couldn’t breathe. I had what I now know to be panic attacks.

In first year of university, I struggled again: too much freedom, student loan money and a massive jump in difficulty from school. This led to what I’d now say was mild-moderate depression. I was tired all the time, and felt overwhelmed and prone to tears and frustration.

The next issue was getting a VT place. In 2011, in Glasgow, I didn’t place in the first or second round. I went to Shetland for a clearing interview and was unsuccessful. I genuinely thought of throwing the final year exam so I could stay in university another year and make myself the best candidate for the 2012 VT places.

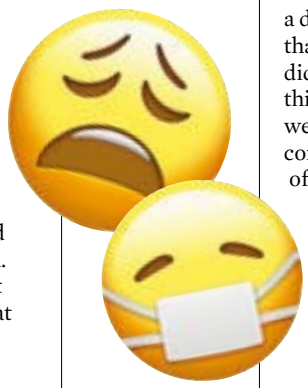
When English clearing opened, I headed down to Wallasey in the Wirral for my first successful interview. However, during the race for VT positions and the run-up to practical finals I began to suffer from excruciating back pain. I was constantly tired. Living in a new city and working full-time for the first time was hard, and it was taking its toll.

Next I started DF2, six months maxfacs and six months PDS. I struggled with maxfacs. Five days in, I started crying in the middle of the ward in front of the consultant and the other SHOs. I was so stressed and also upset at seeing nice, kind people so unwell. The dark humour used by some of the SHOs and nurses didn’t work for me.

My back problems only got worse and my fiancé begged me to leave the job. But I stuck it out, and some kind nurses and SPRs got me through.

Then it was PDS for six months, then called community. I wasn’t used to its structure where administrators seemed to be given a lot of power, and I rebelled. Anxiety started when patients did or didn’t show up and I worried I couldn’t manage them. I think it was obvious that I didn’t want to kowtow to the politics that goes on in a hospital setting and I gave a pretty scathing review of maxfacs. I didn’t place as an SHO.

So, to general practice it was. But I lasted just three months in my first practice. The owner and practice manager made my life hell. I sought legal advice then bided my time until I had another position lined up. Not a great start to my associate career.



Nicola McMillan

I stayed at my second associate position for 18 months. But I found it difficult to meet the high expectations of the Edinburgh patient base. They seemed to want private treatment for an NHS fee, and I found that very intimidating.

I was endlessly tired and I started getting so anxious that I would vomit my breakfast in the morning and consider pulling into oncoming traffic on the way to work. Not to kill myself, just to get injured enough so that I wouldn’t have to be a dentist for a bit.

I started seeing a life coach, also a dentist. She tried to assure me that it wasn’t my fault if my patients didn’t brush their teeth. But in my thinking, we’re professionals and we should be persuasive enough to convince patients of the importance of brushing their teeth daily. With that logic, it’s our fault they ever need treatment. I felt guilty if I found a cavity.

I locumed in a lovely practice for six months before starting in my current job. But there have been times, for personal reasons, that I have felt lonely and isolated. I knew I was fighting depression. The staff were kind and would ask if I was ok. But I was embarrassed. I felt it would come across as laziness and sometimes it was all I could do to drag myself to work in the morning.

I love being a dentist. Sometimes I hate the way patients treat us, but I truly enjoy my job. In the past year I’ve thrown myself into helping other people through Mental Dental. I’m honoured to be a part of it. It’s not been without its challenges. People are capable of saying some fairly dreadful things. Even in this day and age, and among fellow care professionals, there are those who simply do not understand or have any empathy for those who have to cope with their demons.

I have had some pretty unpleasant experiences online. But we believe that by providing people with a forum, we are going some way to helping. We would always suggest that people who are suffering seek professional help, the sooner the better.

My GP, my fiancé and friends have helped me through some difficult times and for that I’m truly grateful. I believe in the kindness of our profession. Dentists will give up their time willingly to help others in need. What more can you ask for?

VOCO
THE DENTALISTS

The packable version of **ADMIRA FUSION** has a certain **firmness** to it that allows very **good adaptation** to cavity form and is **easy to manipulate** and sculpt. It can be polished to a **high shine** and it has a surface hardness giving a **long-lasting, natural lustre** and of course **stain resistance.**

Dr James Robson BDS, Principal Dentist

CREATE MINIMALLY INVASIVE AESTHETICS
CONTACT VOCO FOR YOUR FREE STARTER KIT.

AMAL

On 1 July 2018, restrictions on the use of dental amalgam came into effect throughout the UK. In this article we look at what these restrictions are, how they came about, advice for adhering to them and what is likely to happen next

WORDS
SARAH ALLEN

SDCEP implementation advice

DR MICHELE WEST, SDCEP

WHAT ARE THE NEW RESTRICTIONS ON DENTAL AMALGAM USE?

New environmental restrictions on dental amalgam use in specific patient groups came into effect in the UK on 1 July 2018. The use of dental amalgam for the treatment of patients under 15 years old, of pregnant or breastfeeding patients or of deciduous (primary) teeth in any patient is now only allowed when deemed strictly necessary by the dental practitioner based on the patient's dental or medical needs.

The restrictions, which are specified in EU regulations and applicable in UK law, have been introduced to fulfil the requirements of the global Minamata Convention, to which the UK government is a signatory. This United Nations Convention aims to reduce the use of mercury and mercury containing products, including dental amalgam, on environmental grounds.

WHY IS THERE A NEED TO PHASE-DOWN THE USE OF DENTAL AMALGAM?

There is no evidence that mercury present in dental amalgam presents a direct health risk to individuals who have amalgam restorations or to dental staff. However, when released into the environment, the mercury within dental amalgam can be converted by aquatic microorganisms into a form that can accumulate to toxic levels in fish and other marine life and enter the human food chain. Therefore, by contaminating the environment, dental amalgam can contribute indirectly to the risk to human health from mercury. Phasing-down the production, use and disposal of dental amalgam will help to reduce this indirect risk.

WHAT SUPPORT IS THERE FOR DENTAL PRACTITIONERS?

Advice published in June 2018 by the Scottish Dental Clinical Effectiveness Programme (SDCEP) aims to support dental professionals across the UK in interpreting and implementing the restrictions on dental amalgam use specified in Article 10(2) of the EU regulations. The advice emphasises the importance of caries prevention and provides information about alternative caries management approaches and restorative materials to inform practitioners' clinical decision-making.

Examples of situations where dental amalgam may be the only feasible treatment option are presented, and these include when there is an allergy or local adverse reaction to alternative materials, or when moisture control or patient co-operation is insufficient to allow the use of an alternative to dental amalgam for the treatment required. It is advisable to document the reasons why amalgam was used in individual circumstances for these patients in the patient's record.

It is recognised that, in light of the new regulations, patients may have concerns about existing or planned dental amalgam restorations. Consequently, information leaflets for the patient groups to which the restrictions apply are provided by SDCEP to help practitioners explain the new regulation, support discussions with patients and parents or carers and provide reassurance about their care.

The Scottish Government has issued a memorandum to NHS Boards and Practitioner Services advising of new arrangements relating to the phasing down of dental amalgam, including a new amendment to the Statement of Dental Remuneration (SDR).

HOW WAS THE SDCEP IMPLEMENTATION ADVICE DEVELOPED?

The advice was requested by the UK Chief Dental Officers and has been developed following a rapid process that draws on elements of SDCEP's accredited guidance development methodology. A short-life working group that included experienced dental practitioners and experts in restorative and paediatric dentistry, drawn from across the UK, was convened to develop the advice. UK-wide consultation was conducted to allow stakeholders to comment on and contribute to the development of the advice. The Dental Faculties of the Royal College of Surgeons of Edinburgh, the Royal College of Physicians and Surgeons of Glasgow and the Faculty of General Dental Practitioners (UK) have endorsed the implementation advice.

WHAT NEXT?

While this has been standard practice in Scotland for several years, the banning of bulk form dental amalgam and the requirement for amalgam separators both come into effect on 1 January 2019 to help reduce amalgam waste and improve use, storage and waste management. The next key milestone designated by the EU regulations is the requirement for a national plan by 1 July 2019 on measures to phase-down the use of dental amalgam.

In the longer term, the direction of travel may be towards a more substantial phase-down and ultimately phase-out of dental amalgam, as has been implemented in countries such as Norway and Sweden, although at this point this is speculation. A feasibility study by the European Commission on the potential phase-out of the use of dental amalgam, preferably by 2030, is due to report by 2020.

For advice and patient information visit:
www.sdcep.org.uk/published-guidance/dental-amalgam

The new regulations on dental amalgam use

Regulation (EU) 2017/852 on Mercury contains the following provisions relating to dental amalgam:

Article 10(1): from 1 January 2019, dental amalgam shall only be used in pre-dosed encapsulated form.

Article 10(2): from 1 July 2018, dental amalgam shall not be used for dental treatment of deciduous teeth, of children under 15 years and of pregnant or breastfeeding women, except when deemed strictly necessary by the dental practitioner based on the specific medical needs of the patient.

Article 10(3): by 1 July 2019, each Member State shall set out a national plan concerning the measures it intends to implement to phase down the use of dental amalgam.

Article 10(4): from 1 January 2019, operators of dental facilities in which dental amalgam is used or dental amalgam fillings or teeth containing such fillings are removed, shall ensure that their facilities are equipped with amalgam separators for the retention and collection of amalgam particles, including those contained in waste water.

The advice in a nutshell

Early prevention

Prevention is at the core of many national policies and it is estimated that every £1 spent on prevention leads to £3 saved on later restorative work. The guidance refers to current UK guidelines around the prevention of caries in children, which make recommendations including behaviour change, dietary and toothbrushing advice, and the use of fluoride varnish and sealants.

Use of alternative techniques and materials

The advice recommends the use of alternative techniques and materials in the treatment of dental caries and restoration. For children and deciduous teeth this includes the use of methods such as the Hall Technique, sealant or infiltration and preventive only interventions. The advice states that many of the same approaches

Dental amalgam phase-down timeline

10 October 2013

Minamata Convention on Mercury agreed

Signed by the EU and individual Member States including UK

18 May 2017

EU Regulation on Mercury agreed

16 August 2017

Minamata Convention enters into force

1 January 2018

EU and UK mercury regulations come into force

and principles can be used for caries management in adults and permanent teeth. It discusses the use of alternative materials such as resin composites and glass-ionomers. The advice is clear that extraction should not be considered as an alternative to the use of dental amalgam.

Minimum intervention dentistry (MID)
MID is an approach that aims to prevent and control oral disease and encompasses oral health promotion, prevention and minimally invasive operative interventions.

Changes to the Statement of Dental Remuneration

In order to facilitate the phase-down of dental amalgam use relating to the regulations which came in on 1 July 2018, the following changes have been made to the Statement of Dental Remuneration as SDR Amendment no.138:

- An increase on the previous fee for the restoration of retained deciduous teeth in adults
- Introduction of a new fee for the restoration of all posterior teeth in children under 15 whether deciduous or permanent
- No change relating to the treatment of pregnant or breastfeeding women as they already receive non-amalgam treatment in Scotland .

Deciduous teeth

The directive necessitates the use of non-amalgam filling material for deciduous and retained deciduous teeth in all patients. The directive does not require a change in item 44(a), which allows for use of alternative filling material in minors. However, the directive does necessitate a new item, 14(c)(1)(ii) (new code 1428), for retained deciduous teeth in adult patients.

14(c)(1)(ii) in retained deciduous teeth: filling, including any dressing, pulp capping and pin or screw or acid etch retention and other preparatory treatment:

1428 [TS] per tooth £8.75 (£7.00)

You should also note that 14(c)(1)(i) now refers only to permanent teeth in adults (the reference to retained deciduous teeth has been removed).

Children under 15 years of age

The Directive necessitates the use of non-amalgam filling for posterior teeth in children under 15 years of age. The revised SDR has a new item 43, with the inclusion of two new codes (4301) and (4302) to allow for a resin filling in patients under 15 years of age (the standard proviso for replacement fillings also applies):

43 Treatment Special to Minors: Resin* filling, including acid etch retention in permanent molar and pre-molar teeth in a patient under 15 years of age at the beginning of a course of treatment:

4301 [TS] per tooth £18.40 (£0.00)

4302 [TS] per tooth where the mesio-occlusal and/or disto-occlusal surfaces are involved £28.60 (£0.00).

Proviso to Item 43: No fee shall be payable under item 43 to repair or replace a filling where the same dentist provided the original filling to the same tooth within the previous 11 complete calendar months unless the repair or replacement is required as a result of trauma.

*Resin means any non-amalgam filling.

1 July 2018
Restrictions on the use of dental amalgam in specific patient groups come into effect in the UK

1 January 2019
Provisions to relating to dental amalgam encapsulation and disposal come into effect in the UK

1 July 2019
National plan for phase-down measures required

On the other hand...

It's fair to say that the issue of the phase-down of dental amalgam is not without controversy. The advice published by SDCEP in June 2018 is welcome and has been greeted positively. However, it is important to recognise that there are some outstanding issues, the solution to some of which is not in the remit of SDCEP, or any similar group or organisation that produces guidelines, *writes Sarah Allen.*

There has been significant concern among dental professionals that some of the alternative materials are not durable enough for use in certain circumstances in posterior teeth, and to allow equitable access to those materials which have optimal and durable properties would require significantly increased financial remuneration. In addition, it is widely accepted that alternative materials such as composite take approximately double the time to place than amalgam. Coupled with the increased material costs of composite (and relevant etch-bond systems required for their use) over amalgam, dental professionals working under NHS regulations in Scotland may be faced with the prospect of potentially having to do more for less. Although changes have been made to the SDR, there is wide-spread concern among practitioners that the increase to existing fees, and the ones newly introduced, are inadequate to allow for the use of composites that can be a realistic, ethical and durable alternative to amalgam.

Prevention rightly plays a key part in the phase-down and, though the profession is in agreement that prevention must be at the core of national policies around oral health, it is a long-term strategy which does not really support practitioners dealing with the reduction of amalgam use in the short and medium term. Many dental professionals would like to see more practical and financial support from both within the profession and government, to facilitate appropriate implementation of the changes required by amalgam phase-down. Additionally, though the advice is clear that exceptions can be made when there are real medical or dental reasons, many would still like more clarity around how this applies when treating certain groups such as young teenagers with high caries risk or those under 15 with learning disabilities or autism.

Bearing in mind that the phase-down of dental amalgam is purely environmental, another question lingers around the environmental impact of alternative materials. Concerns have been raised about the environmental effect of resin composites, but, as little is known about the longer term environmental effect of these materials, there is a need for further research in this area.

This is, of course, the first of several stages of the phase-down of amalgam, and there is hope that some of these outstanding issues can be addressed more fully in future guidance. This will, of course, require support from both the UK and Scottish governments as many of the questions that remain cannot be fully addressed as part a guidance development process, or be solved by the guidance itself. Ideally, all stakeholders must work together nationally and internationally to co-ordinate implementation of and appropriately support the phase-down during the different stages required by Minimata, however far it is implemented.

It is imperative that the wider issues around funding and support for this very significant change to UK dentistry, which have been brought into focus by these developments, are more effectively and efficiently addressed.

> "IT IS IMPERATIVE THAT THE WIDER ISSUES AROUND FUNDING AND SUPPORT ARE MORE EFFECTIVELY AND EFFICIENTLY ADDRESSED"

Scottish Dental
Conference & Exhibition 2018

Friday 7 September | Crowne Plaza Hotel Glasgow

BDA
British Dental Association

A day for the whole dental team

Digital dentistry
Aged dentition
Oral cancer
Stress resilience
Periodontics
Restorative dentistry

REGISTER NOW

BDA members: **£230** Non-members: **£290**
DCPs / VDPs / GPTs / Senior members: **£80**
Extra and Expert members: **£50**
Students: **£50**

Sponsored by
MDDUS
UK INDEMNITY, ADVICE & SUPPORT

020 7563 4590
bda.org/scottishdental

Up to **6 hours** **verifiable CPD**

Mixed perceptions

Two GDC surveys find that patients take a harsher view of professional misconduct than those in the dental profession but are more tolerant when it comes to personal behaviour. Andrew Collier examines the figures

Dental patients generally want to see harsher sanctions imposed against members of the profession who are guilty of clinical misconduct than practitioners themselves, according to two comprehensive new studies.

However, in the main, patients tend to seek a more lenient outcome in cases of personal misconduct – in other words, incidents that have nothing to do with their dental care – than dentists feel is appropriate.

The findings come from the Final Report of the General Dental Council's Registrant Survey 2017-18 and the GDC Public & Patient Survey 2017-18. The registrants survey, issued to a random sample of 36,000 registrants, elicited more than 6,200 responses.

Research was carried out by quantitative means through an online survey as well as using the qualitative methodology of focus groups and in-depth telephone interviews.

Respondents were presented with a series of different potential scenarios involving misconduct by a dentist or dental nurse. They were then asked what sanction should be imposed in that particular situation.

The options were no action; a reprimand, leaving the professional free to practice; conditions such as agreeing to further training or taking steps to improve; suspension for a set period of time; or the ultimate step of being struck off the register.

In the hypothetical scenario of a dentist or dental nurse posting racist comments on their personal Facebook page – a case of personal rather than clinical misconduct – four per cent of dentists felt no action should be taken.

A total of 33 per cent felt there should be a reprimand, 18 per cent conditions imposed, 25 per cent suspension and 14 per cent striking off.

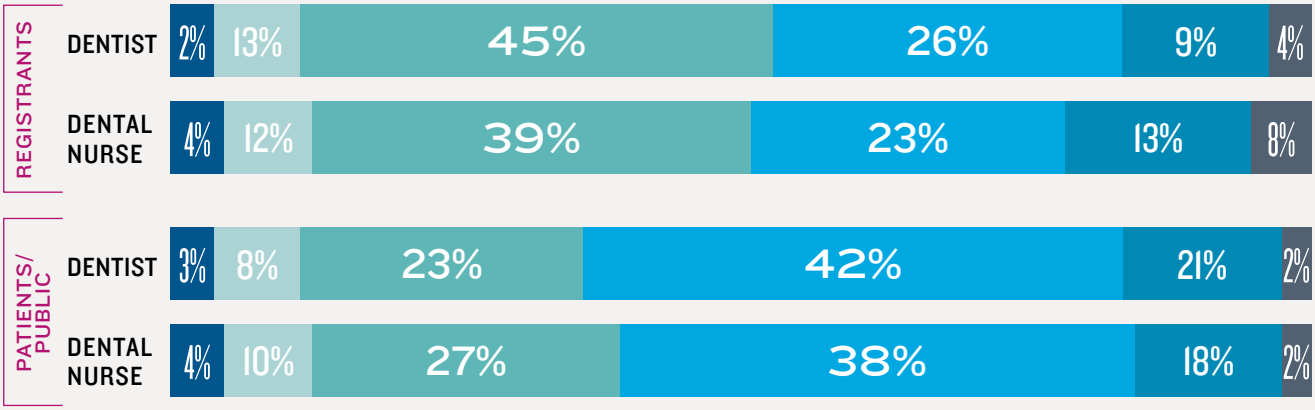
Among patients and the public surveyed, a significantly larger percentage – 13 per cent – felt no action should be taken.

If a dental nurse were involved, in some categories the figures were slightly, though not dramatically, different.

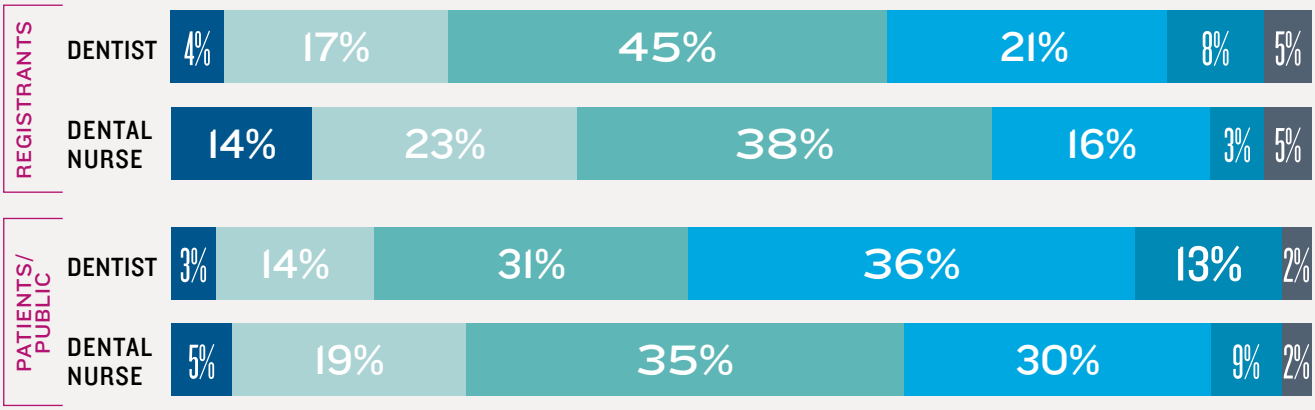
Five per cent opted for no action, 37 per cent for a reprimand, and 22 per cent for suspension. Exactly as with the dentists, 18 per cent opted for conditions being

Right: the survey findings of registrants' views and those of patients and the public on the appropriate actions in hypothetical professional scenarios

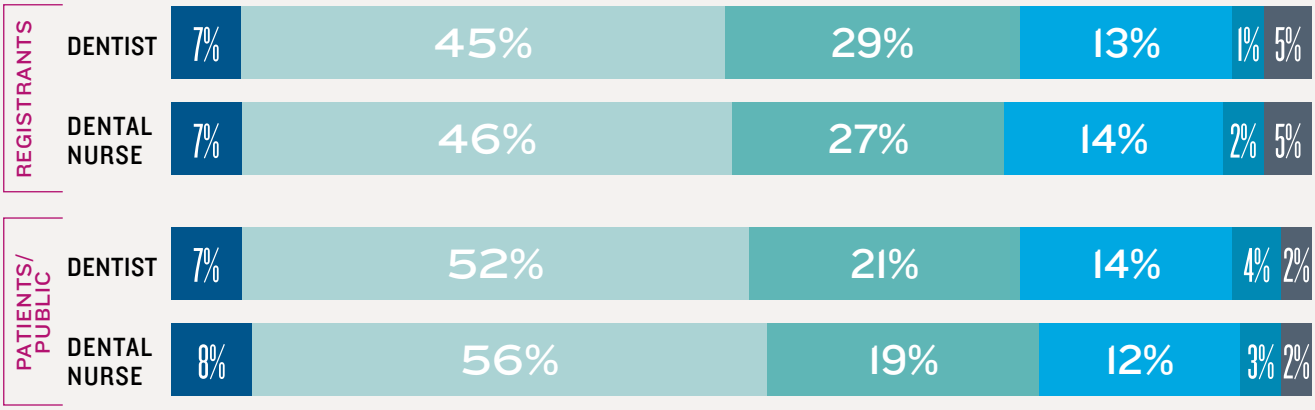
A DENTIST ACCIDENTALLY PRESCRIBES/A DENTAL NURSE ACCIDENTALLY GIVES THE WRONG MEDICATION TO A PATIENT, AND THERE ARE SERIOUS SIDE EFFECTS



A DENTIST REMOVES THE WRONG TOOTH/A DENTAL NURSE READS NOTES OUT WRONG [AND] AS A RESULT THE DENTIST REMOVES THE WRONG TOOTH



A DENTIST/DENTAL NURSE GIVES A PATIENT A RUDE RESPONSE TO A COMPLAINT A PATIENT HAS MADE ABOUT THEM



No action Reprimand Conditions Suspension Strike off register Don't know

attached and 22 per cent for suspension. A total of 14 per cent saw striking off as the best remedy.

There was a lower demand from patients than for the professionals (26 per cent and 12 per cent respectively) for a reprimand or the imposition of conditions on dentists, but interestingly a higher figure (28 per cent) felt suspension was appropriate, as was the case with striking off (19 per cent).

All the respondents in the survey have been anonymised, but one dental practitioner commented that he would personally opt for a reprimand, explaining this sort of conduct would not actually endanger patients.

"It's unprofessional and possibly bringing the profession into disrepute, but if it's a first offence it should just be [a case of] 'don't do that again'", he added.

"If they're a repeat offender, that's different because they haven't responded to a reprimand, so you need to move onto something else."

And a dental nurse commented: "I'd personally suggest conditions. There may be more training that's needed, whether in the sense of the racist comments or in the sense of how to use social media in a positive way without bringing our profession into disrepute."

Varying attitudes

Another question relating to personal rather than clinical misconduct concerned a dentist or dental nurse being charged for drunk and disorderly behaviour on a night out.

In this case, attitudes varied dramatically between patients and registrants, with more members of the public feeling that no action should be taken against a dentist – 42 per cent, compared to 10 per cent among dentists and 13 per cent among dental nurses.

A total of 34 per cent of dentists felt a reprimand would be the most appropriate outcome, compared to 37 per cent of dental nurses.

A smaller percentage of the patient cohort favoured the harsher outcomes compared to dentists – 10 per cent against 19 per cent for a dentist having conditions attached, 13 per cent against 26 per cent for suspension, and six per cent against seven per cent for striking off.

"You've got to have a certain level of professionalism," said one dentist respondent. "If somebody is acting unprofessionally and has been charged, I think they are bringing our profession into disrepute."

However, another responded: "The only way that drunkenness will affect anyone is if the dentist comes into work [still under the influence] the next day, and that's a different thing completely." Another remark was: "Until they're actually found guilty, there should be no action."

> "IF THEY NEVER TOOK A MEDICAL HISTORY IT SHOULD BE A SUSPENSION, BECAUSE THEY'RE DANGEROUS. IF THEY HAD A BUSY DAY AND FORGOT TO ASK THE PATIENT, THEN IT'S NOT AS SERIOUS"

Clinical scenarios

Moving on to questions relating to clinical misconduct, one hypothetical scenario in the survey involves the case of a dentist prescribing, or a dental nurse accidentally giving, the wrong medication to a patient, leading to serious side-effects and an admission to hospital.

In this case, two per cent of dentists felt no action should be taken, with a further 13 per cent opting for a reprimand, 45 per cent the attachment of conditions, 26 per cent suspension and nine per cent striking off.

In the case of dental nurses, twice as many – four per cent – felt there should be no action, with 12 per cent favouring a reprimand and 39 per cent conditions. The figure for suspension was slightly lower at 23 per cent, but for striking off, it was substantially higher at 13 per cent.

The public/patient cohort tilted more strongly to the harsher outcomes. Three per cent went for no action, but eight per cent opted for a reprimand, 23 per cent for conditions, 42 per cent for suspension and 21 per cent for striking off.

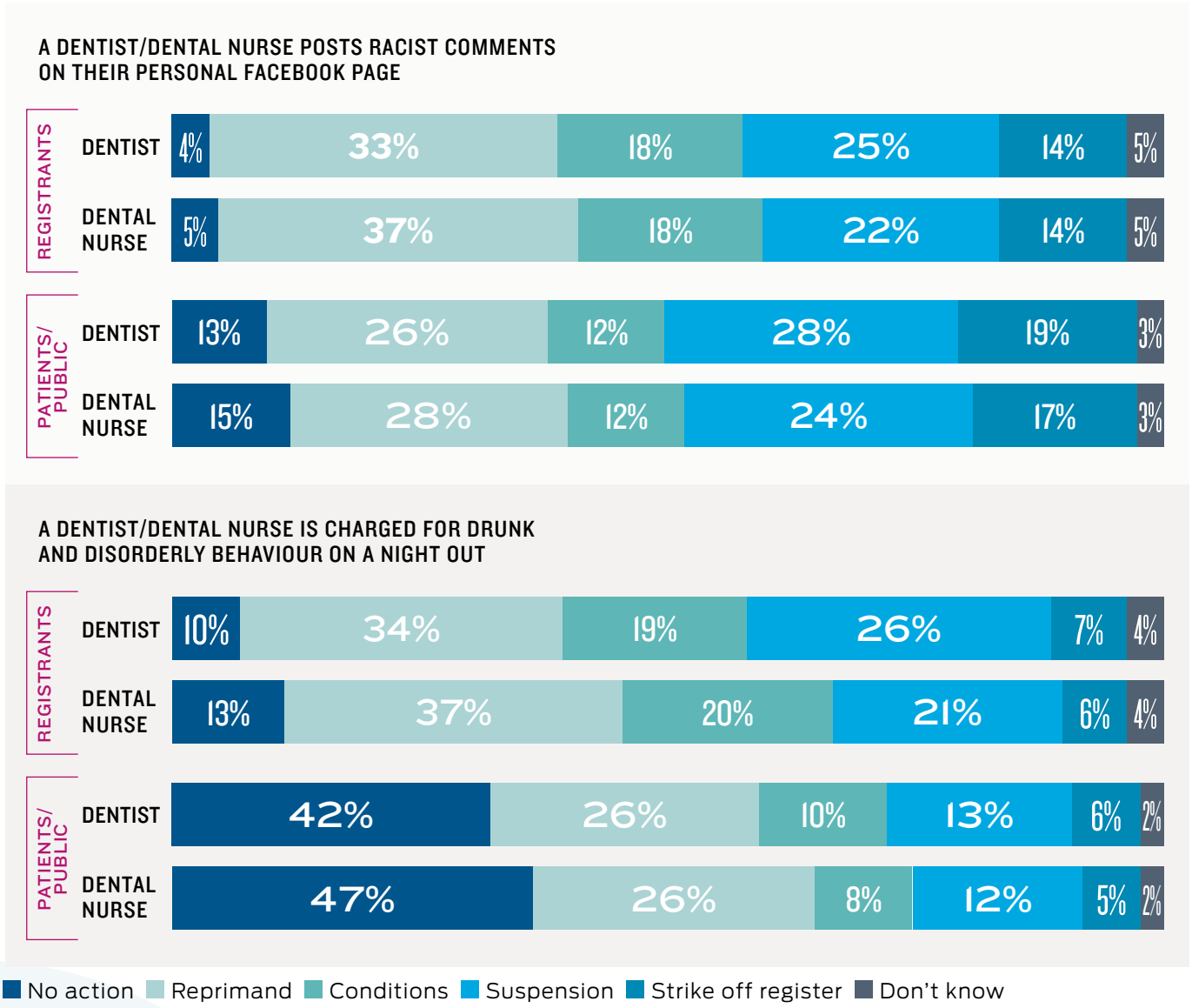
Some respondents felt that the dentist or dental nurse should not necessarily be judged too harshly, particularly if it was an honest mistake or partly the fault of the patient in some way.

"If it happened, it would be a learning point to know that you can't just rely on their medical history and you need to ask them every time," said one dentist.

Another commented: "It's a mistake ... if this person is actively trying to do harm to someone then it's different ... the person may just need more training."

Another view was that if the error highlighted a more serious failure, such as a practice not updating patients' medical histories, then more serious action should be taken.

"If they never took a medical history, it should be



a suspension, because they're dangerous," said one participant. "If they had a busy day and forgot to ask the patient, then it's not as serious."

And a dental nurse commented: "If it was a mistake, then it should be a reprimand, but maybe with some training but not with any restrictions in place. How can you restrict a dentist from writing prescriptions?"

In a different question on potential clinical error, respondents were asked about the case of either a dentist removing the wrong tooth, or a dental nurse reading the notes wrongly and the dentist extracting the wrong tooth as a result. Among patients, three per cent thought no action should be taken; 14 per cent opted for a reprimand; 31 per cent felt conditions should be attached; 36 per cent believed suspension to be the most appropriate outcome; and 13 per cent thought the professional should be struck off.

Dentists veered more towards the softer outcomes, with almost half – 45 per cent – believing the mistake should result in conditions being attached. Four per cent felt no action should be taken and 17 per cent believed a reprimand to be the best solution.

Mitigating factors

There was a notably softer response to the suggestion of harsher penalties within this cohort, with just 21 per cent believing in suspension and eight per cent opting for striking off.

Among dental nurses, a dramatically higher figure – 14 per cent – felt no action should be taken. A reprimand garnered 23 per cent support, while 38 per cent opted for conditions. There was also lower support for the toughest measures among nurses than from dentists, with a figure of 16 per cent favouring suspension and just three per cent opting for striking off. "It's a training issue, potentially," said one dentist, while another said: "If they had done it 10 times it's different, but what if it's a one-off?"

Yet another comment was: "I can imagine the younger dentists who have just come out of dental school would be quite scared. They would think it's quite a serious thing to take a wrong tooth out."

However, some professionals observed there could be mitigating factors, such as clinical decisions concerning extractions sometimes being complex.

It was pointed out that it isn't always a simple task to determine which tooth should be removed, particularly when it is being taken out to try to ease pain on the basis of information provided by the patient.

"You could take one tooth out and the next day the patient still has pain and says you've taken the wrong one out," said one dentist. "It could be that the pain was coming from both of them."

And of the potential outcomes of suspension or striking off, one dental nurse remarked: "It's so harsh!"

Above: the responses of the public and patients on personal conduct were starkly different to those of the professionals

Further information is available on the GDC's website

Above and beyond

Beth Bradley is an Irish, soon-to-be-final-year dental student at the University of Leeds and current BDJ Student *editor. Following a tough fourth year of study involving significant clinical sessions, revision and exams, she was keen to explore what dental professionalism meant to her*

According to the General Dental Council's (GDC) 2013 publication *Continuing Professional Development for Dental Professionals,* a dental professional will be "highly qualified and skilled whilst always accountable to a higher code of conduct". Like any profession, dentistry possesses what the American College of Dentists (ACD) called, "a level of exclusive expertise". Not only as qualified dentists but also as dental students, all behaviours should uphold the principles of the GDC Standards.

In this article I will explore dental student professionalism by discussing its ethical relevance, how we uphold professionalism within ourselves and with our patients, and how, in a world where teamwork is essential, we can attain the best professionalism possible.

By definition, a professional is governed by a higher standard of practice, and the 2013 GDC Standards outline the fundamental ethical principles that demonstrate how any dental professional *must* act. These standards, alongside the 2016 American Dental Association Code of Professional Conduct, represent a dental student's obligatory behaviour. This obligatory behaviour can often be overlooked as we embark on university careers, where we are faced with a variety of new life choices and opportunities.

The Young Dentist (2017) indicated that to be deemed professional, the way in which a dentist/dental student acts should be deemed appropriate by members of the public and professional colleagues. Having felt this responsibility myself, I feel it is important to recognise the professionalism demonstrated by thousands of young dental students every year as we manoeuvre through the whirlwind of undergraduate training alongside peers, enjoying perhaps more frivolous carefree university experiences.

According to Trathen and Gallagher 2009, what sets a professional apart from others is a drive and devotion to strive beyond what they *must* do. It is important to consider that what an individual *must* do is often governed by fear of sanction or reprimand. However, what one *ought* to do is often controlled by a set of internalised and individual moral codes. So, as the ACD put it, a professional dental student should, throughout their scope of practice strive to pursue *beyond* what they must do to uphold the best interests of their patients. This may be through going the extra mile for a patient, booking in more clinical time or lab practice, or perhaps spending a few hours helping a colleague understand a specific lecture. It is these little extras which set a true dental professional apart from the rest.

Our own professionalism should permeate all aspects of our training, through interactions with patients, clinical team and peers and in our own personal professional development.

The Young Dentist (2017) highlights that a dental professional will demonstrate:

- attention to detail
- a desire to seek development and enhancement of their skills
- a willingness to acknowledge and learn from their mistakes.

To me these traits are key elements of professionalism, and ones which I try to maintain throughout my studies.

As a young dental professional maintaining the patient's and community's confidence in myself and the dental profession is vital. I admire so many members of this profession and view preservation of its integrity as a key element of my own professionalism.

The GDC states that we should "maintain, develop and work within [our] professional knowledge and skill". As a dental student I am responsible for my own learning and aim to have the necessary knowledge, skills and attitudes of a registered dental professional. This can be achieved by actively seeking opportunities to develop a skillset and enhancing capabilities in addition to the required studying and taking of exams. Continuous professional development will hopefully provide essential up-to-date care for my patients in the future.

According to the GDC, dentistry as a profession requires excellent and effective teamwork to deliver exceptional patient care. Universities offer a vast array of opportunities for professional development. Through dental societies,

WORDS
BETH BRADLEY

> IT IS IMPORTANT TO RECOGNISE THE PROFESSIONALISM DEMONSTRATED BY THOUSANDS OF YOUNG DENTAL STUDENTS EVERY YEAR AS WE MANOEUVRE THROUGH THE WHIRLWIND OF UNDERGRADUATE TRAINING"
>
> BETH BRADLEY

clubs and the many extracurricular activities on offer, there are countless chances to develop teamworking, communication and organisational skills. As dental students we should harness these chances to enhance our professionalism.

The GDC dictates that a true dental professional must communicate effectively with patients with uncompromising veracity. Optimal communication skills necessary to build a successful rapport with a patient are an essential proficiency of any dental professional. A skill which must quickly be learned by any young dental student. A report by the Parliamentary and Health Service Ombudsman in January, 2015, indicated that "Poor communication [was] at the heart of many dental complaints", highlighting the importance of maintaining professionalism regarding patients by ensuring continuous effective communication with them on every level, thus maintaining the vitally important patient satisfaction essential to a successful dental practitioner.

The best interests of the patient are central to any patient interaction and this concept is paramount to any treatment decisions. As you know, obtaining valid, informed consent from a patient for treatment is a vitally important facet of professionalism regarding patient care. As a dental student, by achieving sufficient consent for treatment, one exhibits a comprehensive knowledge of procedures, the ability to provide an unbiased presentation of the reasonable treatment alternatives and consequences, and the capacity to ascertain the level of competency of a patient.

I am sure every dental student knows that leadership qualities are an essential attribute for any dental professional, whether in a position of formal leadership or not. The Department of Health encourages a multidisciplinary approach to optimise patient management within dental school. This way all members of the clinical and educational teams engage to deliver the best possible patient care. We should have an in-depth knowledge of other disciplines' skill set for appropriate referrals, hence working within our own skill set, and ensuring the best possible patient care by utilising connections within the service.

So, a truly professional dental student *must* abide closely to the laws and standards laid-down within the GDC'S Student Fitness to Practice and, as aptly described by Trathen and Gallagher: "A [true] professional must always seek to go [above and] beyond what one must do."

FURTHER READING

American College of Dentists. 2012. *Ethics Handbook for Dentists*

https://acd.org/PDF/Ethics_Handbook_for_Dentists_(s).pdf

American Dental Association. 2016. *Principles of Ethics & Codes of Professional Conduct.* http://www.ada.org/~/media/ADA/Publications/Files/ADA_Code_of_Ethics_2016.pdf?la=en

Department of Health. 2013. *Delivering high quality, effective, compassionate care: Developing the right people with the right skills and the right values*. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/203332/29257_2900971_Delivering_Accessible.pdf

General Dental Council. 2013. *Continuing Professional Development for dental professionals*.

http://www.gdc-uk.org/Newsandpublications/Publications/Publications/Continuing%20Professional%20Development%20for%20Dental%20Professionals.pdf

General Dental Council. 2013. *Standards for the Dental Team*

http://www.gdc-uk.org/dentalprofessionals/standards/pages/default.aspx

General Dental Council. 2013. *Student Fitness to Practice*

http://www.gdc-uk.org/newsandpublications/publications/publications/studentftpapril10web_260310[1].pdf

NHS Leadership Academy. 2013. *The Healthcare Leadership Model*

http://www.leadershipacademy.nhs.uk/wp-content/uploads/dlm_uploads/2014/10/NHSLeadership-LeadershipModel-colour.pdf

Parlimentary and Health Service Ombudsman. 2015. *Poor communication is at the heart of many dental complaints, finds ombudsman*

http://www.ombudsman.org.uk/about-us/news-centre/press-releases/2015/poor-communication-is-at-heart-of-many-dental-complaints,-finds-ombudsman.

The young dentist. 2017. *Professionalism and integrity* http://www.theyoungdentist.com/uk/features/ethics/387-professionalism-and-integrity

Trathen, A. and Gallagher, J. E. 2009 Dental professionalism: definitions and debate. British Dental Journal http://www.nature.com/bdj/journal/v206/n5/full/sj.bdj.2009.164.html?cookies=accepted

Biodentine™

"First ever Biological Bulk Fill"

Paediatrics | **Restorative** | Endodontics

For vital pulp therapy, bulk-filling the cavity with Biodentine™ makes your procedure better, easier and faster:

- Pulp healing promotion: proven biocompatibility and bioactivity
- Reduced risk of failure: strong sealing properties
- Only one material to fill the cavity from the pulp to the top
- Similar mechanical behaviour as natural dentine: ideal for bulk filling

The final enamel restoration will be placed within 6 months.

ACTIVE BIOSILICATE TECHNOLOGY

Innovative by nature

Please visit our website for more information: www.septodont.co.uk

Download the Septodont App for product information, case studies, CPD, lecture bookings and more - all at your fingertips

septodont

Symptoms of MDDUS are easily recognised

You wouldn't believe how many dentists across the UK are choosing MDDUS as their indemnity provider? They know we provide 24/7 expert advice and access to indemnity, assistance and support – all at competitive rates. Not only that, they enjoy peace of mind knowing they automatically have lifelong assistance for incidents that occurred during membership – even if they're no longer with us when the matter comes to light.

Our members trust us to put their interests first, knowing that we will always be there when they need us.

For a personalised quote contact Mairi on:

mdixon@mddus.com

0141 228 1267

MDDUS

UK INDEMNITY, ADVICE & SUPPORT

WWW.MDDUS.COM

A rare intraoral presentation of lymphomatoid papulosis

McGrath G[1], Bowen L[2], Busuttil-Naudi K[3], Forsyth C[4], Wright S[5]

[1]Core Trainee in Oral Surgery & Special Care Dentistry, [2]Core Trainee in Oral Surgery, [3]Clinical Senior University Teacher/ Honorary Consultant in Oral Surgery, [4]Speciality Dentist in Oral Surgery, [5]Consultant Pathologist

Department of Oral Surgery, Glasgow Dental Hospital & School, 378 Sauchiehall Street, Glasgow, G2 3JZ.
Department of Pathology, Queen Elizabeth University Hospital, 1345 Govan Road, Glasgow, G51 4TF.
Contact: grainnemcgrath39@outlook.com

Background

Lymphomatoid papulosis (LyP) is defined as a chronic, recurrent, self-healing papulonecrotic or papulonodular skin disease. (1)

• It is very rare, having an estimated incidence rate of 1.2-1.9 cases per million, with intraoral involvement even rarer with very few cases reported in the literature. (2)

• It displays a spectrum of histological appearances with its most concerning presentations suggestive of malignant lymphoma.

Despite its potentially alarming histology, the lesions tend to follow a benign clinical course resolving spontaneously within 3-12 weeks, sometimes leaving superficial scars. (1)

• It is characterised by recurrent crops of skin lesions, predominantly on the trunk and limbs.

• It tends to affect adults and can last for years or decades.

• It has no curative available treatment, but patients have a good prognosis with a 100 per cent five-year survival rate. (1)

Despite this, physicians tend to have a guarded approach as these patients have a small but increased risk of developing malignant lymphomas such as Hodgkins lymphoma or primary cutaneous anaplastic large-cell lymphoma. (1)

A case of intraoral LyP at Glasgow Dental Hospital is presented below, highlighting the challenges of diagnosing and managing this incredibly rare presentation.

Case description

A 72-year-old male was referred urgently by his consultant dermatologist to the Oral Surgery department at Glasgow Dental Hospital with regard to concerning tongue ulcers. He gave a four-day history of a tender and swollen tongue, which he associated with the onset of a new medication, sacubitril/valsartan. The lesions arose two days after he started this medication. The sacubitril/valsartan was discontinued by the referring practitioner when he reported the tongue lesions. He had an extensive medical history including COPD, heart failure, myocardial infarctions and lymphomatoid papulosis affecting his skin, as well as polypharmacy. He was a heavy smoker and had a history of alcohol abuse.

Extraoral examination was unremarkable. Intraoral examination revealed two large raised, firm ulcers on the left dorsal surface of the tongue crossing the midline. The larger ulcer measured 1.5cm in diameter. The acute onset of the lesions was unusual. Oral lesions are not listed as a side effect of sacubitril/valsartan in the BNF. Their concerning characteristics led to the provisional diagnosis of a squamous cell carcinoma and consequently an urgent incisional biopsy.

Histopathology

Histopathological analysis, from the incisional biopsy of the tongue suggested a CD30 positive lymphoproliferative disorder.

Discussion

Without the availability of previous skin biopsies for comparison, a more sinister diagnosis may have been suspected, potentially leading to more aggressive and debilitating management.

The differential diagnosis included mucosal/cutaneous anaplastic T-cell lymphoma, mucosal/cutaneous involvement by systemic anaplastic lymphoma, transformed mycosis fungoides and lymphomatoid papulosis. Fortunately, identical cellular changes were seen in previous skin biopsies and the unusual and correct diagnosis of lymphomatoid papulosis of the tongue was given.

Oral involvement of LyP is incredibly rare, with fewer than 20 cases reported in the literature. (2) In these cases intraoral lesions predominantly affected the dorsal surface of the tongue, similar to this case, but lesions on the commissures and the uvula were also reported. For these cases, most of the patients already had a diagnosis of LyP affecting the skin prior to oral involvement, which would have greatly facilitated the diagnostic challenge.

The patient was under the care of Dermatology regarding his LyP skin lesions. Past management of his skin lesions included:

• a conservative approach – allowing time for spontaneous resolution

• excision

• topical steroids.

Further treatment options suggested in the literature for LyP skin lesions include:

• a low-dose of oral methotrexate – the most effective treatment available to suppress the development of new LyP skin lesions

• PUVA (psoralen ultraviolet A light therapy)

• chemotherapy.

Unfortunately, there is limited guidance in the literature on how to manage intraoral LyP lesions. However, as these

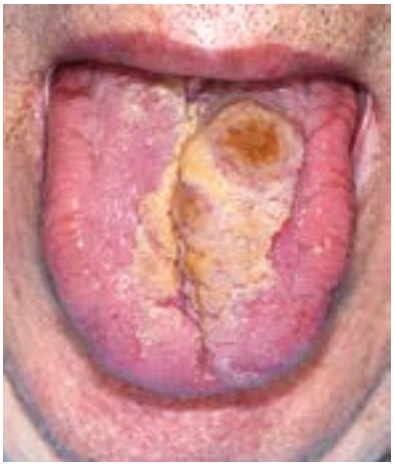


Figure 1: Clinical photograph of the tongue ulceration at initial examination

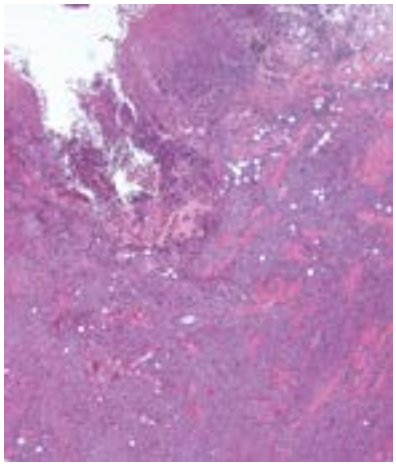


Figure 2: Low-power view, X20 magnification, H&E stain
It demonstrates:
· heavily stratified squamous epithelium towards one edge
· an area of ulceration towards the other edge
· diffuse infiltrate of lymphoid cells in the underlying skeletal muscle bundles

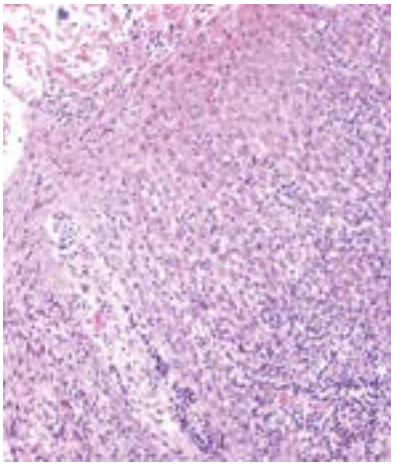


Figure 3: Medium-power view, X100 magnification, H&E stain
It demonstrates:
· the squamous epithelium overlying the lymphoid infiltrate
· there is no epidermotropism of the large lymphoid cells

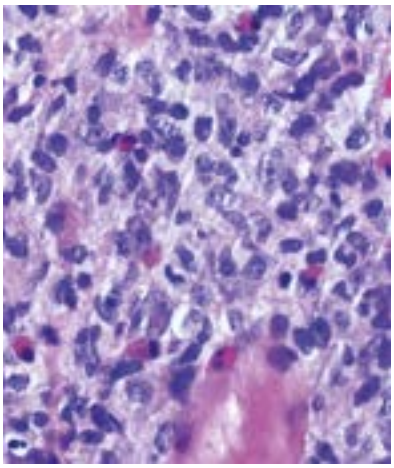


Figure 4: High-power view, X400 magnification, H&E stain
It demonstrates:
· the lymphoid infiltrate
· large, pleomorphic lymphoid cells with vesicular nuclei and prominent nucleoli

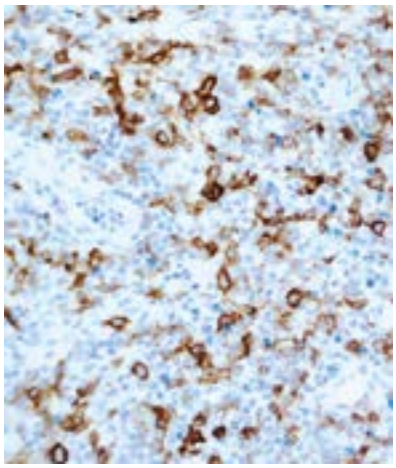


Figure 5: High-power view, X200 magnification, CD30 immunostain
It demonstrates:
· the large lymphoid cells stained positively with CD30 immunostain in a membranous and cytoplasmic pattern

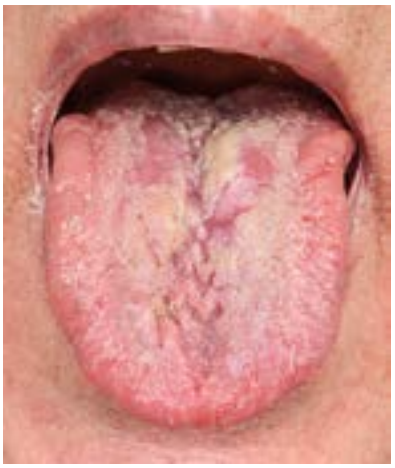


Figure 6: Clinical photograph of the tongue at two-week review appointment. There was some firmness on palpation. The lesion had improved dramatically

lesions often resolve spontaneously, treatment is not always advocated.

After liaising with Dermatology, a topical betamethasone mouthwash was prescribed for symptomatic control and the lesions were monitored until they resolved within a three-week time period without incident.

Learning points

• Diagnosis and management of this rare condition and even rarer intraoral presentation proved challenging due to the lack of cases and guidance in the literature.

• As the condition can be easily misinterpreted for something more sinister, it is important that clinicians and pathologists are aware of this, to prevent unnecessarily aggressive management.

• Formal reporting of intraoral cases of LyP is crucial to build up a reference base for future clinicians.

• Long-term follow-up is important as these patients are at risk of developing a malignant lymphoma.

REFERENCES

1: Willemze R, Jaffe ES, et al. WHO-EORTC classification for cutaneous lymphomas. Blood 2005; 105:3768-3785

2: Sciubba J, Said-al-Naief et al. Critical review of lymphomatoid papulosis of the oral cavity with case report. Oral Surg Oral Med Oral Pathol Oral Endod 2000; 90:195-204

3: Belijaards RC, Willemze R. The prognosis of patients with lymphomatoid papulosis associated with malignant lymphomas. British Journal of Dermatology 1992; 126(6):596-602

4: Kempf W, Levi E, et al. Fascin expression in CD30-postive cutaneous lympoproliferative disorders. Journal of Cutaneous Pathology 2002. 29(5): 295-300

CBCT and clinical decision-making

Arvind Sharma, BDS(Dund), MSc(Endo), MJDFRCS(Eng), MFDSRCPS(Glas)

Arvind Sharma presents the second and final part of a structured critical review to evaluate the question whether the use of cone beam computed tomography (CBCT) in endodontics has an influence on clinical decision-making.

Methodology

The methodology of this review is based on the aforementioned steps, as suggested by Boland et al 2014. Below is a brief summary of the methods used.

The following structure was therefore employed:

1) Inclusion criteria
2) Exclusion criteria
3) Search engines
4) Search strategy with literature search
5) Study selection
6) Quality assessment
7) Data extraction.

The topic considered was discussed with my supervisor and also with my peers to solicit their views.

The author attended a British Endodontic Society conference held in London in March 2015 and met Dr Patel (one of the speakers that day) when the topic of this review was discussed.

The author and Dr Patel corresponded by email, and Dr Patel suggested that there is a lack of evidence in this field due to lack of clinical studies and suggested that a systematic review would be difficult in his opinion. This led the author and his supervisor to consider a structured critical review instead.

Due to the aforementioned reasons and since the author's time and resources are limited, a traditional systematic review was not possible. It was decided, therefore, to design and conduct a structured critical review of the literature to answer the question posed.

F&T Level	Studies Identified
3-Diagnostic Thinking Efficacy	4
4-Therapeutic Efficacy	3
5-Patient Outcome Efficacy	1

Table 4
Summary of included studies with associated F&T hierarchy levels

The review question was then formalised as a statement of my intention of the structured critical review. This was developed from what was found through the available evidence to what I further planned to find out. A theoretical approach, exploring factors that lead to a process, was to be taken.

Results

The search identified eight publications that qualitatively or quantitatively assessed the use of CBCT in endodontics combined with clinical decision-making with respect to three levels of a six-tiered hierarchical model. (Level 3 diagnostic thinking efficacy, Level 4 therapeutic efficacy and Level 5 patient outcome efficacy).

The following table (table 3), shows the final eight papers that were included in this study along with the F&T hierarchy levels.

As can be seen from the above table (table 4), four papers were identified investigating the diagnostic thinking efficacy, three papers investigating the therapeutic efficacy and one paper investigating patient outcome.

Of all the eight studies, six concluded that CBCT made an influence in clinical decision-making and two did not.

Meta-analysis

A meta-analysis was not performed. Only a narrative summary of the data is presented since the included studies did not meet the criteria for conducting a meta-analysis. The differences across the trials, including inconsistent patient characteristics presented in some of the papers, small sample sizes, diversity in protocols (interventions and comparators were not uniform across all studies), and the inconsistency in reporting outcomes (not all studies reported the same results), including statistical data (not present in one study), precluded a statistical synthesis of the included trial results.

Discussion

The aim of this structured critical review was to answer the question, "does the use of CBCT in endodontics influence clinical decision making?" Of the eight studies chosen for this review, 75 per cent concluded that CBCT did influence decision-making whereas 25 per cent of studies concluded that CBCT did not influence clinical decision-making.

From the evidence analysed in this review, CBCT appears to have a positive influence in clinical decision-making in endodontics. However, when data was extracted, the six studies (75 per cent) did show limitations, which will be discussed below.

Although the literature search provided an abundance of evidence on CBCT, the evidence available relating to the review question was limited. When considering the hierarchy of evidence (randomised controlled trials being the most robust form of study) and application of the inclusion criteria to the results of the searches there was a lack of studies in this area with only nine studies meeting criteria. One of the reasons for this is due to

Study	Study Title	F&T Levels
1. Abuabara et al 2012	Efficacy of clinical and radiological methods to identify second mesiobuccal canals in maxillary first molars	3
2. Balasundaram et al 2012	Comparison of Cone-beam computed tomography and periapical radiography in predicting treatment decision for periapical lesions: a clinical study	3
3. Davies et al 2015	The detection of periapical pathoses using digital periapical radiography and cone beam computed tomography in endodontically retreated teeth-part 2: a one- year post-treatment follow-up	3+4
4. Ee et al 2014	Comparison of endodontic diagnosis and treatment planning decision using cone-beam volumetric tomography versus periapical radiography	4
5. Hashem et al 2015	Clinical and radiographic assessment of the efficacy of calcium silicate indirect pulp capping: a randomised controlled clinical trial	3
6. Kurt et al 2014	Outcomes of periradicular surgery of maxillary first molars using a vestibular approach: a prospective, clinical study with one year of follow-up	5
7. Mota de Almeida et al 2014	The impact of cone beam computed tomography on the choice of endodontic diagnosis	4
8. Mota de Almeida et al 2014	The effect of CBCT on therapeutic decision-making in endodontics	3

Table 3: The final eight papers included in this study

ethical considerations in relation to the exposure of patients to radiation when taking a CBCT for an in-vivo trial/study. So, although CBCT is being more commonly used in clinical endodontic practice, the number of in-vivo studies is lacking. This was further confirmed by personal communications with the well-published author and committee member of the European Society of Endodontology, Dr Shanon Patel.

The limited literature search was further compounded by the fact that Fryback and Thornbury Levels 3, 4 and 5 were applied and this resulted in fewer relevant studies. A number of studies were found but were mainly on levels 1 (technical quality of image) and 2 (diagnostic accuracy, sensitivity and specificity). The inclusion criteria of human, English language and in-vivo studies again limited the number of studies since published animal and foreign language studies were excluded. Applying a search for 'all studies' gave a wider net for the search with non-relevant studies due to their hierarchical level of evidence being excluded. This was the case with Kurt et al 2003, which was a cross-sectional observational study.

Considering the available studies, the author believes that all or at least a representative sample of the available evidence relating to the study question was obtained.

Overall, on a hierarchy of evidence, since only two randomised controlled trials were included, the evidence gathered was not of the highest calibre. The included studies all had limitations that were either discussed by the individual authors or were identified during this review's quality assessment process. The limitations identified included, small sample sizes in most studies, history and clinical information (signs and symptoms) not always provided, the number and clinical experience of observers varied from novice to most skilled, the radiation dose used with the CBCT modality was not always validated, the resolution of CBCT images was not always discussed as image enhancement may or may not have affected the image quality and hence results and detailed statistical data were not disclosed in three studies.

In one study where periradicular surgery was being performed, a microsurgical approach was not used, which is now accepted as the gold standard in retrograde endodontics, both in Europe and North America. The ability, for example, to identify artefacts due to beam hardening that could be misdiagnosed as a carious lesion is an important point. Therefore, image interpretation is still an area that requires further training especially for less experienced clinicians.

There were limitations with this structured critical review study with respect to the time that was spent on the literature search, the final selection of the chosen studies, the quality assessment and data extraction. This was mainly due to the part-time nature

of this study and there only being one individual, namely the author, executing the various stages of this structured critical review.

It is the author's opinion that by having more than one individual working on various aspects of this study, bias may have been eliminated, leading to a more rigorous study process.

The limitations were related to the methodological part of this study. Specifically:

- Inclusion/exclusion criteria-language bias, publication bias was considered in a limited way with the use of one researcher
- Literature search resources – three search engines only being employed
- Search strategy – one researcher, using mainly electronic databases only and study selection
- Quality assessment only being performed by one researcher
- Data extraction only being performed by one researcher and was not cross-checked by another person. However, data was put aside for one week and then checked again to compare that the sets of the data were the same.

With all of the above limitations considered, it is the author's opinion that a thorough and reproducible literature search was performed using appropriate and relevant search terms, quality assessment of the chosen studies enabled the most appropriate studies to be used for data extraction purposes and since the conclusions reached for this critical review process are similar to other reviews in this field of study, the author is confident that the review process was conducted with appropriate methodology, is clear, reproducible, thorough and transparent.

Although the overall findings of this review seem to suggest that CBCT is influential in clinical decision-making, it is the author's opinion that the findings cannot be generalised and applied to the everyday clinical practice of endodontics. There was disparity in the studies in terms of their design, sample size, age range, male-female ratio, setting, sample definition, F&T level, examiners used (experience and number of) and use of statistical data, which means it is difficult to make an absolute comparison of outcomes and reach a definitive conclusion based on the chosen studies. CBCT does have an important place in endodontic clinical decision-making but its use should still be limited as ESE recommend.

In conclusion, this critical review has shown that although most of the available evidence appears to show that CBCT does influence clinical decision-making in endodontics, high-quality longitudinal studies are lacking, and more research is required. Based on the current available evidence, the ESE guidelines seem appropriate and should be applied accordingly. The studies by Balasundaram et al 2012, Davies et al 2015 and Mota de Almeida et al 2014 all looked at the detection of periapical radiolucencies and, as discussed earlier, did not concur with their results. CBCT has a useful place in clinical decision-making in endodontics but its use should be kept for complex cases where radiographs do not give sufficient information. This would resonate with the ESE guidelines.

As discussed earlier, there are implications in using CBCT, namely, cost of equipment, training required for the use and interpretation of CBCT and importantly the radiation dose the patient is exposed to. No doubt, CBCT can be relevant and useful in endodontics and can have an influence in clinical decision-making, which in turn may help a patient with complex symptoms that routine investigative methods have proved limited. However, the overall consensus of the studies do not recommend the routine use of CBCT in endodontics but recommend its consideration when other methods of diagnosis prove to be inconclusive in reaching a definitive diagnosis. Again, this would in line with guidelines produced by the ESE. Looking into the future, if CBCT equipment can expose the patient to less radiation, perhaps in line with the amount produced by intra-oral radiographs, its use may well increase particularly if coupled with a more affordable price tag. Increasing CBCT education at undergraduate and postgraduate level would improve knowledge and application in the clinical setting. This would ultimately give the clinician more tooth detail, which could in turn improve patient care and the reputation of endodontics as a dental discipline amongst patients.

Conclusions

This structured critical review has shown that there is limited evidence on the influence of CBCT in clinical decision-making in endodontics. The available evidence does however seem to suggest that there is a place, although limited, for CBCT use in endodontics with decision-making. Application of ESE guidelines should be followed until further research can be carried out in this interesting and clinically relevant imaging modality

CPD

VERIFIABLE CPD QUESTIONS

Aims and objectives

› To give the reader an understanding of CBCT as a modern imaging tool and its application in endodontics
› To provide details of the evidence surrounding clinical decision making in endodontics
› To highlight the clinical applications where use of CBCT in endodontics would be advantageous

Learning outcomes

› To understand the basics of how CBCT works and its clinical application in endodontics
› To be able to recognise when the use of CBCT may help clinical decision-making

Example question

What kind of process was used to carry out the research?
a) Systemic review?
b) Randomised controlled trial?
c) Structured critical review?
d) Questionnaire?

How to verify your CPD

Go online to www.sdmag.co.uk and click on the CPD tab to access all our CPD Q&As and certificates.

REFERENCES

ABUABARA, A., BARATTO-FILHO, F., AGUIAR ANELE, J., LEONARDI, D.P. and SOUSA-NETO, M.D., 2013. Efficacy of clinical and radiological methods to identify second mesiobuccal canals in maxillary first molars. ActaOdontologicaScandinavica, 71(1), pp. 205-209.

ARAI Y, TAMMISALO E, IWAI K, HASHIMOTO K, SHINODA K (1999) Development of a compact computed tomographic apparatus for dental use. Dentomaxillofacial Radiology 28, 245–8.

BALASUNDARAM, A., SHAH, P., HOEN, M.M., WHEATER, M.A., BRINGAS, J.S., GARTNER, A. and GEIST, J.R., 2012. Comparison of cone-beam computed tomography and periapical radiography in predicting treatment decision for periapical lesions: a clinical study. International journal of dentistry, 2012.

BERGENHOLTZ, G. and KVIST, T., 2014.Evidence-based endodontics. Endodontic Topics, 31(1), pp. 3-18.

BROWN, J., JACOBS, R., LEVRING JGHAGEN, E., LINDH, C., BAKSI, G., SCHULZE, D. and SCHULZE, R., 2014. European Academy of DentoMaxilloFacial Radiology Basic training requirements for the use of dental CBCT by dentists: a position paper prepared by the European Academy of DentoMaxilloFacial Radiology. Dentomaxillofac. Radiol, 43(1), pp. 20130291.

CHEUNG, G., WEI, W. and MCGRATH, C., 2013. Agreement between periapical radiographs and cone-beam computed tomography for assessment of periapical status of root filled molar teeth. International endodontic journal, 46(10), pp. 889-895.

CHRISTIANSEN, R., KIRKEVANG, L., GOTFREDSEN, E. and WENZEL, A., 2009. Periapical radiography and cone beam computed tomography for assessment of the periapical bone defect 1 week and 12 months after root-end resection. Dentomaxillofacial Radiology, 38,pp.531-536.

DAILEY, B., MINES, P., ANDERSON, A. and SWEET, M., 2010. The use of cone beam computer tomography in endodontics: Results of a questionnaire. 2010. AAE Annual Session abstract presentation PR10. Journal of Endodontics, 36, pp. 567.

DAVIES, A., PATEL, S., FOSCHI, F., ANDIAPPAN, M., MITCHELL, P.J. and MANNOCCI, F,2015. The detection of periapical pathoses using digital periapical radiography and cone beam computed tomography in endodontically retreated teeth - part 2: a 1 year post-treatment follow-up. International endodontic journal, 48(6), pp. 582-592.

DE ALMEIDA, MOTA F J, KNUTSSON, K. and FLYGARE, L., 2015. The impact of cone beam computed tomography on the choice of endodontic diagnosis. International endodontic journal, 48(6), pp. 564-572.

EE, JONATHAN BDS,D.D.S., F.R.C.D., FAYAD, MOHAMED I D D S and JOHNSON, B.R.D.D.S., M.H.P.E., 2014. Comparison of Endodontic Diagnosis and Treatment Planning Decisions Using Cone-beam Volumetric Tomography Versus Periapical Radiography. Journal of endodontics, 40(7), pp. 910-916.

ESTRELA, C., HOLLAND, R., DE ARAJO ESTRELA, C R, ALENCAR, A.H.G., SOUSA-NETO, M.D. and PCORA, J.D., 2014.Characterization of successful root canal treatment. Brazilian dental journal, 25(1), pp. 3-11.

EUROPEAN COMMISSION. Evidence-based guidelines on cone beam CT for dental and maxillofacial radiology. Office for Official Publications of the European Communities. Radiation Protection 172, 2012.Cited December 2013: [about 154 pp.]. Available from: http://ec.europa.eu/energy/nuclear/radiation_protection/doc/publication/ 172.pdf 30.

FRYBACK, D.G. and THORNBURY, J.R., 1991.The efficacy of diagnostic imaging. Medical decision making, 11(2), pp. 88-94.

GRONDAHL, H. and HUUMONEN, S., 2004. Radiographic manifestations of periapical inflammatory lesions: How new radiological techniques may improve endodontic diagnosis and treatment planning. Endodontic Topics, 8(1), pp. 55-67.

HASHEM, D., MANNOCCI, F., PATEL, S., MANOHARAN, A., BROWN, J.E., WATSON, T.F. and BANERJEE, A., 2015. Clinical and Radiographic Assessment of the Efficacy of Calcium Silicate Indirect Pulp Capping A Randomized Controlled Clinical Trial. Journal of dental research, 94(4), pp. 562-568.

HILTON, T.J., 2009. Keys to clinical success with pulp capping: a review of the literature. Operative dentistry, 34(5), pp. 615.

JENSEN, A. R., 1985. The nature of the black-white difference on various psychometric tests: Spearman's hypothesis. Behavioural and Brain Sciences, 8(02), pp. 193-219.

KRUSE, C., SPINNETO, R., WENZEL, A. and KIRKEVANG, L.L., 2015. Cone beam computed tomography and periapical lesions: a systematic review analysing studies on diagnostic efficacy by a hierarchical model. International endodontic journal, 48(9), pp. 815-828.

KURT, S.N., STN, Y., ERDOGAN, Z., EVLICE, B., YOLDAS, O. and ZTUNC, H., 2014. Outcomes of periradicular surgery of maxillary first molars using a vestibular approach: a prospective, clinical study with one year of follow-up. Journal of Oral and Maxillofacial Surgery, 72(6), pp. 1049-1061.

KVIST, T. and REIT, C., 2000. Postoperative discomfort associated with surgical and nonsurgical endodontic retreatment. Dental Traumatology, 16(2), pp. 71-74.

KVIST, T., REIT, C., ESPOSITO, M., MILEMAN, P., BIANCHI, S., PETTERSSON, K. and ANDERSSON, C., 1994. Prescribing endodontic retreatment: towards a theory of dentist behaviour. International endodontic journal, 27(6), pp. 285-290.

KVIST, T. and REIT, C., 1999. Results of endodontic retreatment: a randomized clinical study comparing surgical and nonsurgical procedures. Journal of endodontics, 25(12), pp. 814-817.

LEDLEY, R.S. and LUSTED, L.B., 1959. Reasoning Foundations of Medical Diagnosis Symbolic logic, probability, and value theory aid our understanding of how physicians reason. Science, 130(3366), pp. 9-21.

LIANG, Y., JIANG, L., GAO, X., SHEMESH, H., WESSELINK, P.R. and WU, M., 2014. Detection and measurement of artificial periapical lesions by cone-beam computed tomography. International endodontic journal, 47(4), pp. 332-338.

LOFTHAG-HANSEN, S., HUUMONEN, S., GRNDAHL, K. and GRNDAHL, H., 2007.Limited cone-beam CT and intraoral radiography for the diagnosis of periapical pathology. Oral Surgery, Oral Medicine, Oral Pathology, Oral Radiology, and Endodontology, 103(1), pp. 114-119.

MOTA DE ALMEIDA, F J, KNUTSSON, K. and FLYGARE, L., 2014. The effect of cone beam CT (CBCT) on therapeutic decision-making in endodontics. Dentomaxillofacial Radiology, 43(4), pp. 564-572, (20130137).

MOZZO, P., PROCACCI, C., TACCONI, A., MARTINI, P.T. and ANDREIS, I.B., 1998. A new volumetric CT machine for dental imaging based on the cone-beam technique: preliminary results. European radiology, 8(9), pp. 1558-1564.

NG, Y., MANN, V. and GULABIVALA, K., 2010. Tooth survival following non-surgical root canal treatment: a systematic review of the literature. International endodontic journal, 43(3), pp. 171-189.

PATEL, S., WILSON, R., DAWOOD, A. and MANNOCCI, F., 2012. The detection of periapical pathosis using periapical radiography and cone beam computed tomography–Part 1: pre-operative status. International endodontic journal, 45(8), pp. 702-710.

PATEL, S., DURACK, C., ABELLA, F., ROIG, M., SHEMESH, H., LAMBRECHTS, P. and LEMBERG, K., 2014. European Society of Endodontology position statement: The use of CBCT in Endodontics. International endodontic journal, 47(6), pp. 502-504.

PATEL, S., DURACK, C., ABELLA, F., SHEMESH, H., ROIG, M. and LEMBERG, K., 2015. Cone beam computed tomography in endodontics–a review. International endodontic journal, 48(1), pp. 3-15.

POPE, O., SATHORN, C. and PARASHOS, P., 2014. A comparative investigation of cone-beam computed tomography and periapical radiography in the diagnosis of a healthy periapex. Journal of endodontics, 40(3), pp. 360-365.

REIT, C. and KVIST, T., 1998. Endodontic retreatment behaviour: the influence of disease concepts and personal values. International endodontic journal, 31(5), pp. 358-363.

RIGOLONE, M., PASQUALINI, D., BIANCHI, L., BERUTTI, E. and BIANCHI, S.D., 2003. Vestibular surgical access to the palatine root of the superior first molar: "low-dose cone-beam" CT analysis of the pathway and its anatomic variations. Journal of endodontics, 29(11), pp. 773-775.

ROSEN, E.D., TASCHIERI, SILVIO D D S, DEL FABBRO, M., BEITLITUM, I.D. and TSESIS, I.D., 2015. The Diagnostic Efficacy of Cone-beam Computed Tomography in Endodontics: A Systematic Review and Analysis by a Hierarchical Model of Efficacy. Journal of endodontics, 41(7), pp. 1008-1014.

SACKETT, D.L., ROSENBERG, W.M., GRAY, J.A., HAYNES, R.B. and RICHARDSON, W.S., 1996. Evidence based medicine: what it is and what it isn't. BMJ: British Medical Journal, 312(7023), pp. 71.

SCARFE, W.C., LEVIN, M.D., GANE, D. and FARMAN, A.G., 2010. Use of cone beam computed tomography in endodontics. International journal of dentistry, 634567.

STAVROPOULOS A, WENZEL A, 2007. Accuracy of cone beam dental CT, intra oral digital and conventional film radiography for the detection of periapical lesions. An ex vivo study in pig jaws. Clinical Oral Investigation, 11(1),pp.101–106.

STRINDBERG, L.Z., 1956. The dependence of the results of pulp therapy on certain factors: an analytic study based on radiographic and clinical follow-up examinations. Mauritzon. Acta Odontologica Scandinavica; 14(suppl 21): 1-175.

TSAI, P., TORABINEJAD, M., RICE, D. and AZEVEDO, B., 2012. Accuracy of cone-beam computed tomography and periapical radiography in detecting small periapical lesions. Journal of endodontics,38(7), pp. 965-970.

VOORDE, H.V. and BJORNDAHL, A.M., 1969. Estimating endodontic "working length" with paralleling radiographs. Oral Surgery, Oral Medicine, Oral Pathology, 27(1), pp. 106-110.

WU, M.K., SHEMESH, H. and WESSELINK, P.R., 2009. Limitations of previously published systematic reviews evaluating the outcome of endodontic treatment. International endodontic journal, 42(8), pp. 656-666.

Mouth guard use among children: Has the GAA policy made a difference?

David S. Evans, Department of Public Health, HSE West, Galway
Margaret O' Malley, HSE West Dental Services, Castlebar

Abstract

In 2014 the Gaelic Athletic Association (GAA) in Ireland made mouth guard use mandatory. The study aimed to assess the impact of the policy on mouth guard use among schoolchildren. We replicated a 2011 study of mouth-guard use. A questionnaire was sent to parents of children attending 4th-6th class in a random sample of 25 schools across HSE West. A total of 298 questionnaires were returned for analysis. A total of 68 per cent of children were reported as wearing mouth guards (22 per cent in 2011). Mouth guard use has increased in all sports with Gaelic football experiencing the largest increase (16-87 per cent).

The main type of mouth guard used is 'boil and bite' with 2 per cent using a mouth guard from a dentist. Mouth guard use was significantly greater where schools and sports clubs that children attended had policies on mouth guard use. The number of sports accidents involving teeth reduced from 52 per cent in 2011 to 15 per cent in the current study. Rugby and Gaelic football were perceived to have the highest risk of injury to teeth if a mouth guard is not worn. The study suggests that the GAA policy has made a difference in the promotion of mouth guard use. Policies on mouth guards and their promotion need to be undertaken to increase usage in other sports and to promote the use of custom-made mouth guards.

Background

Although participation in sport plays a key role in the promotion of child health, there are risks that sports activities may lead to injuries, particularly to the teeth. Studies have found that sporting activities are linked to over a third of dental injuries (US Department of Health and Human Services, 2000). Such injuries can be very upsetting for children, requiring extensive long-term treatment. Dental injuries can be significantly reduced by wearing a mouth guard.

However, prior to 2012, the only sport in Ireland where mouth guards were mandatory was boxing. Some other sports promoted mouth guard use, but did not have mandatory regulations. The Irish Rugby Football Union, for example, advised clubs to adopt a 'no guard, no game' rule.

In 2011, we undertook a survey of mouth guard use among national schoolchildren and found that they were only worn by 22 per cent (O'Malley et al, 2012, 2015). In addition, injuries to permanent teeth represented 87 per cent of all sports injuries. Without mandatory regulations, it appeared that the majority of children, for whatever reason, were not motivated to use mouth guards. In April 2012, the Gaelic Athletic Association (GAA) made mouth guard use mandatory for all ages up to under 21 years, which was extended to adults in 2014.

This represented a significant development in the prevention of dental injury. As with any policy, it is important to determine if it has been effective in promoting mouth guard use in Gaelic football. It is also important to see if mouth guard use in other sports has increased. We therefore conducted a follow-up study to assess its impact on mouth guard use, perceptions of mouth guards in terms of reducing the risk of injury, and school and club policy.

Method

To assess changes in mouth guard use among schoolchildren since becoming mandatory for Gaelic football, we replicated our 2011 study of mouth guard use among schoolchildren. A random sample of 25 schools in HSE West (stratified by county) was selected. School principals sent parents of children in 4th-6th class a confidential self-completion questionnaire for each child attending these classes. The questionnaire sought information from the parents about their child(ren), including sporting activities, policies on mouth guards, mouth guard use, barriers to mouth guard use and history of dental trauma and treatment.

Results

Profile

A total of 298 completed questionnaires were received from 25 selected national schools. More than half (54 per cent) were boys with a mean age of 11 years (range 9 to 13 years). On average, children played two sports with Gaelic football (32 per cent), soccer (25 per cent), basketball (31 per cent) and hurling (25 per cent) being the main sports played. The respondent profile is broadly similar to our original research.

Mouth guard use

Overall, 68 per cent of children were reported as wearing mouth guards while playing sport. The corresponding figure was 22 per cent in 2011. Significantly more parents whose children wore mouth guards were aware of the GAA rules for mouth guard use for Gaelic football (83 per cent compared to 54 per cent). For those that wore mouth guards, figure 1 shows the sports where mouth guards were used. It can be seen that of the sports they played, the main sports that a mouth guard was used was for rugby (88 per cent) and Gaelic football (87 per cent). Compared to 2011, the proportion using their mouth guard for each sport has increased, with Gaelic football experiencing the largest increase (from 16 per cent to 87 per cent).

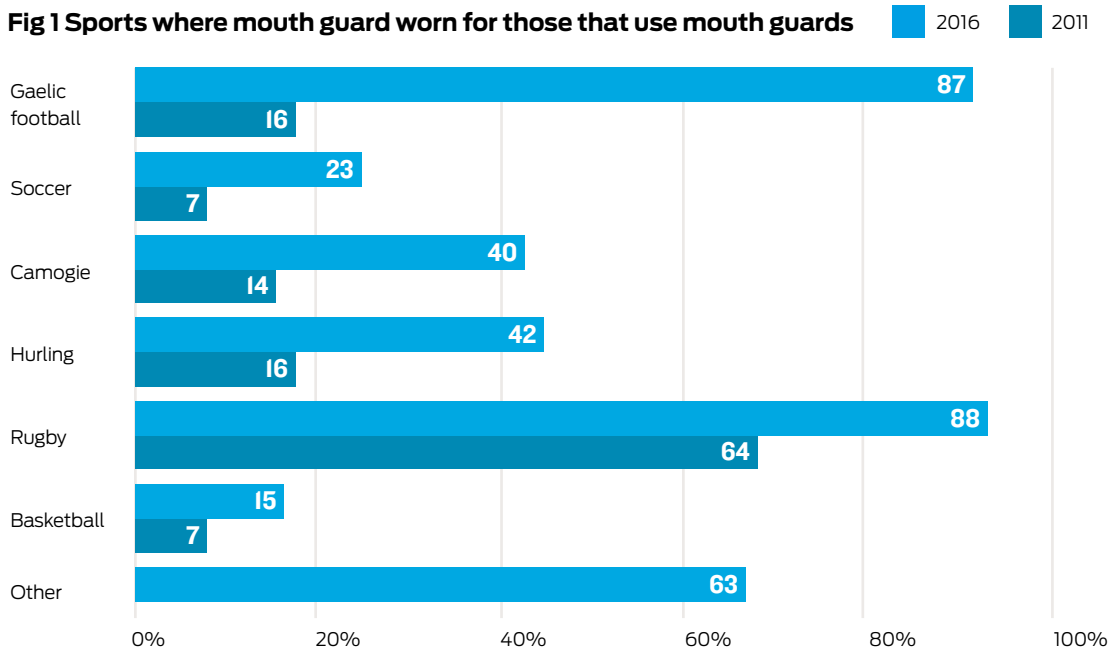
Type of mouth guard

The main type of mouth guard used was 'boil and bite' (64 per cent) with 14 per cent using other types of mouth guards and 2 per cent using a mouth guard from a dentist. This pattern is broadly similar to that found in 2011 (64 per cent, 12 per cent, and 4 per cent respectively with 19 per cent not knowing the type of mouth guard). Half (50 per cent) of parents did not know if the mouth guard from a dentist was safer while 40 per cent reported it was safer or much safer.

School and club mouth guard policy

Table 1 (Overleaf) shows over half the parents reported (51 per cent) that their child's (children) school had a policy

Fig 1 Sports where mouth guard worn for those that use mouth guards



on mouth guards. Only 2 per cent of schools had a policy in 2011. In addition, 63 per cent reported that all or most of the sports clubs children attended had a policy on mouth guards (10 per cent in 2011). Mouth guard use was significantly greater where schools and sports clubs that children attended had policies on their use.

Dental trauma

Accidents to children during sport in the last year were reported by 15 per cent of parents (10 per cent in 2011). Of these, 15 per cent involved teeth (52 per cent in 2011). Of those that had accidents involving teeth, 23 per cent were wearing a mouth guard for the last accident. All of these children (n=3) were using 'boil and bite' mouth guards. Injuries to teeth were to both permanent (63 per cent) and deciduous (80 per cent) teeth. Teeth were broken for almost a third (30 per cent) while over a quarter of parents stated that teeth were pushed out of place (27 per cent) and in need of repair. A quarter visited the dentist straight away, while half visited within one week.

Risk of injury to teeth

Parents were asked to rate the risk of injury to teeth if a mouth guard is not worn while playing a number of sports. Figure 2 shows that for each sport, parents whose children wear mouth guards give a higher risk rating. Overall the sports given the highest risk rating are rugby (86 per cent) and Gaelic football (80 per cent).

Discussion

Gaelic football, as with most team sports, involves physical contact. This increases the risk of dental injury, which can be reduced by wearing a mouth guard. Our study has found that since 2011 mouth guard use by children during sport has increased by 209 per cent. Mouth guard use for all sports has increased, but the most dramatic increase is for Gaelic football which rose by 444 per cent. Parents who are aware of the GAA mandatory mouth guard policy are more likely to report that their children use mouth guards. These findings suggest that the introduction of the policy in 2014 is promoting mouth guard use in Gaelic football with a knock-on effect on other sports. This is a positive development, particularly as Gaelic football is the most popular sport played by children in our study.

Although there has been a knock-on effect on other sports, with the exception of rugby, mouth guard use for other sports remains considerably lower. Rugby does not have a mandatory rule, but mouth guard use is strongly promoted and many clubs have mandatory rules. Parents perceive the risk of dental injury to be lower for sports that do not emphasise mouth guard use. Other sports need to consider promoting mouth guard use and also introducing mandatory rules. There is a risk of dental injury associated with all contact sports. Both soccer and basketball for example have a risk of dental injury from other players, the ground, the ball, and posts.

Without greater promotion and regulation by sports organisations, it is unlikely that other sports will reach the usage levels achieved in Gaelic football and rugby. The importance of promotion and regulation is also demonstrated by the fact that mouth guard use was significantly greater where schools and sports clubs that children attended had policies on mouth guard use. School and club policies have significantly increased since 2011 which appears to be promoting mouth guard use. Parents of children that were in schools or clubs that had mouth guard policies were more aware of the risks of injury to teeth if mouth guards were not worn during sport. There remains considerable scope to introduce more policies, particularly in schools where half did not have a policy in place.

Customised mouth guards from the dentist are the most effective mouth guards, but disappointingly these were only used by 2 per cent of mouth guard users, with this pattern being broadly similar to that experienced in 2011. Half the parents in the study did not know if the mouth guard from a dentist was safer. Parents need to be aware of the safety benefits of customised mouth guards. The GAA do provide information on mouth guards (GAA, 2013) but they do not make recommendations in terms of the preferred type. The use of custom made mouth guards should be promoted and this should be incorporated into policies on mouth guards. As customised mouth guards are more expensive, the GAA suggest that clubs liaise with dental

Fig 2 Risk of injury to teeth if mouth guard is not worn

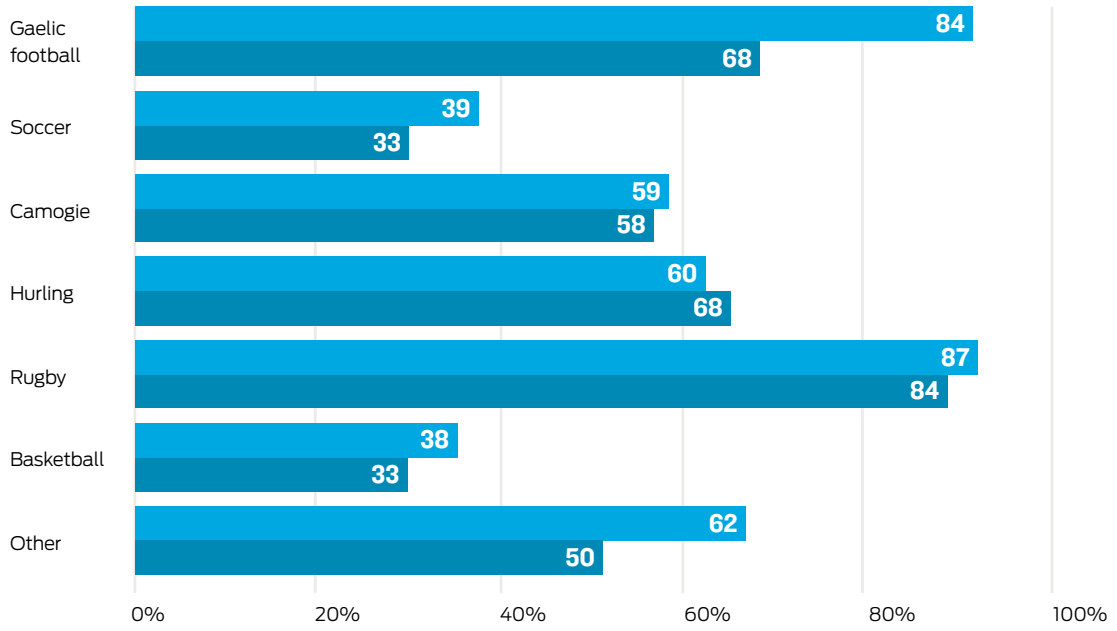


Table 1: School and club policy on mouth guards

		2011		2016	
		Number	%	Number	%
School policy		10	2	149	51
Club policy	**all clubs**	20	4	111	46.1
	most clubs	29	6	41	17
	some clubs	97	21	57	23.7
	no clubs	309	61	32	13.3

practitioners to enable customised mouth guards to be constructed for players in their club at reduced cost. The GAA should ensure that there are mechanisms in place to facilitate this process. All adults and children that play Gaelic football should be able to have customised mouth guards made by a dentist at a reduced cost.

Accidents involving teeth have reduced from 52 per cent to 15 per cent of all sports accidents. Although the number of accidents is small (suggesting caution in interpretation), it may be that the protection provided by mouth guards is helping to reduce dental injuries. This is also supported by the fact that anecdotal evidence suggests that the GAA have experienced a reduction in dental injury claims, and the HSE has experienced a reduction in sports related dental injury traumas. Interestingly, the three people that had a dental injury that were wearing mouth guards were wearing the 'boil and bite' type, which are less protective compared to customised mouth guards.

Conclusion

The GAA have to be heralded for introducing their mouth guard policy. Our study suggests that it is having a positive impact in terms of promoting mouth guard use among children, both in Gaelic football and other sports. We need to build on this success to increase usage in other sports and to promote the use of custom made mouth guards. Parents need to be made aware of the importance of wearing mouth guards for contact sports. This can be achieved with a combination of policy and promotion by schools, clubs, and the HSE.

REFERENCES

GAA, GAA mouth guard Information. Information for clubs, coaches, players, and parents, 2013. Available at: http://learning.gaa.ie/sites/default/files/GAA-Mouthguard-Information-2013-2014.pdf

O Malley, M, Evans, D.S. Hewson, A. Owens, J. Mouthguard Use and Dental Injury in Sport: A Questionnaire Study of National School Children in the West of Ireland, Journal of the Irish Dental Association, V58 (4), August/September 2012, p205-212. Available at: http://www.dentist.ie/_fileupload/JIDA/pdfs%20of%20Journal/2012/2012%20-%2058%20No_%204%20-%20August%20September.pdf

O Malley, Evans, D.S. M. Hewson, A. Owens, J. Speaking out on mouth guards, Ireland's Dental magazine, April 2015

US Department of Health and Human Services, Oral Health in America, A Report of the Surgeon General, Rockville, M.D. 2000. Available at: https://profiles.nlm.nih.gov/ps/access/NNBBJT.pdf

INVISALIGN BRACES AT INFINITY SMILES

Invisalign is a removable brace system that uses a series of custom-moulded aligners to move your teeth.

Invisalign can be used to treat the vast majority of common problems for adults and children. Using advanced 3-D computer imaging technology to project tooth movement, Invisalign allows you to visualise your treatment from start to finish through animated visuals, which can be viewed online.

Whether your smile needs minor improvements or more extensive adjustments, Invisalign can certainly help. It is successful in treating crowded or widely spaced teeth. It can also relieve more complex issues, including overbites, overjets, under bites and even cross bites. In fact, your orthodontist can use Invisalign clear aligners in all or part of many treatment plans.

Every week you will have to replace the old aligner for a new one which will continue to guide your teeth in the necessary direction. Each new aligner may give an initial feeling of minor discomfort for a couple of days - this sensation is typically described as a feeling of pressure and is a sign that Invisalign is working.

The aligners gradually reposition your teeth over the period of treatment – the length of which is determined by the complexity of the case and what you and your orthodontist have agreed to achieve. You will been seen by your Orthodontist for regular appointments in order to check your treatment progress and make sure your teeth are responding to the aligners.

At Infinity Smiles we recommend that aligners must be worn all day, except when brushing, flossing or eating. Fortunately, because you can remove your aligners to eat and drink you can eat all your favourite foods. After each meal, however, you must make sure that you brush your teeth prior to re-inserting your aligners to maintain good hygiene.

Irrespective of the simplicity of your case, your treatment is best handled by an orthodontic specialist, who is trained to diagnose and solve any problems which may arise during your treatment. All the clinicians at Infinity Smiles are specialist orthodontists, dentists with a specialist interest in orthodontics or orthodontic therapists.

The Invisalign system is delivered to the patient as a 'Series' of numbered and labelled aligners. The patient changes to the next sequential aligner within the series every week throughout the treatment.

INFINITY SMILES

Visit our website for more information: **www.infinitysmiles.co.uk**

Queen's Park	East Kilbride	Hamilton	Jordanhill	Kilmarnock	Greenock	Cumbernauld
2 Balvicar Drive, Glasgow, G42 8QS	11 Kirktonholme Road, East Kilbride, G74 1AS	18 Auchingramont Road, Hamilton, ML3 6JT	Randolph Gate, 494 Crow Road, G11 7DQ	33 The Foregate, Kilmarnock, KA1 1LU	84 West Blackhall Street, Greenock, PA15 1XG	38 Westfield Court Grayshill Rd, Cumbernauld, G68 9HQ
Telephone: 0141 423 2994	Telephone: 01355-520290	Telephone: 01698 459922	Telephone: 0141 334 9975	Telephone: 01563 558755	Telephone: 01475 784766	Telephone: 01236 730470

Sales

Valuations

Purchase

Recruitment

Strictly Confidental has been operating for over 16 years within the Dental Profession in Scotland.

We can source and supply all relevant information regarding sales, valuations and acquisitions of Dental Practices and we can also assist with recruitment.

Strictly confidental

0141 641 3963 07906 135 033 www.strictlyconfidental.co.uk

MENTAL HEALTH IN THE WORKPLACE

Stress can affect people in different ways and it's often too easy to overlook the importance of ensuring that staff are supported – and seek help themselves

[WORDS: SUSIE ANDERSON SHARKEY]

IN THE BUSY-NESS OF OUR 21ST century lifestyle, it is easy to become overwhelmed by all the demands placed on us both at work and at home. In many circles, it's even seen as trendy to say we're run off our feet, we're manic busy, we're drowning in a sea of paperwork (one of my favourite sayings!). In fact, if we're not running around like headless chickens, then it looks as if we don't have enough work or we're not working hard enough. The demands of working life definitely take their toll on both mind and body and it's crucial that we find a balance between our work life and our home life so that we can give our best in both worlds.

There is no doubt that people cope in different ways, and what some find a stressful situation others may not find difficult at all. We are all built differently, and it's important that we acknowledge this fact in our workaday life and in dealing with colleagues who may be struggling. What triggers stress factors in my life may be completely different than my colleague sitting 10 feet away from me. So, if we see one of our colleagues who is struggling, what should we do?

First of all, communication is key. Give the opportunity for the member of staff to chat about the problem. What is causing the stress? Is it work related? Often a person is struggling and it's nothing to do with the actual work; it can be something that is happening outside of work, perhaps a difficulty at home or a relationship difficulty, and though, with the best will in the world, we try to leave our outside life at the door when we come to work, in reality it's not always that easy.

If the stress is work related, have a chat and try to come to an arrangement that suits both the practice and the staff member to deal with the issue. This may be a move to another department, a change in hours, further training, seeking professional help: there are usually a number of options depending on the nature of the situation.

> "WE NEED TO TAKE CARE OF OUR PHYSICAL AND MENTAL HEALTH. NO ONE ELSE IS GOING TO DO THIS FOR YOU"

It's important that the member of staff is given time and space to express how they are feeling, how they got to this stage and then work with them to find a solution and how they can move forward. In my experience, it's very rarely just one issue. It's usually a number of issues that have built up over time and rather than speak to someone, the staff member has tried to struggle through things on their own. Every member of staff needs to know that a manager is there for them and to work together to ensure the best possible outcome.

I have been in the situation where I have felt under incredible pressure, I haven't listened to my own body telling me to rest and have unwisely pushed through physical and mental barriers when I should have taken heed to how I was feeling. As a result, I was forced to take time out to allow time for my mind and body to get back on an even keel. Since then, I now take regular holidays, have learned to delegate in the workplace and also have learned that it's okay to say "this is too much for me".

We are part of a team; I don't need or have to work alone and I have a great team who are a great support to me in my extremely demanding job as practice manager at Dental fx. I am there for them and they are there for me. In order for us to work to our maximum capacity, we need to ensure that we take care of our mental and physical health. No one else is going to do this for you. You need to take charge of your life and make the changes necessary to function in all areas of life, both in and outside the workplace.

So, what I have learned, which is relevant whether you are an employee who is in difficulty or whether you are a manager:

1. Admit when you're struggling
2. Get the proper help you need
3. Don't try to cope on your own
4. Be realistic about what you can take on
5. Learn to delegate
6. Work as a team
7. Listen to your body
8. Take regular breaks
9. Know that as a good manager, a business really should be able to run without you while you're on holiday and there is nothing wrong with leaving your work phone at home when you're in the Bahamas!
10. A sense of humour always helps.

If you wish to contact Susie about this article or other practice management issues she can be reached at susie@dentalfx.co.uk

LEADERSHIP – AND HOW TO GET IT RIGHT

The most successful leaders are those who acknowledge that they are lacking in some areas and work hard at developing themselves

[WORDS: ALUN K REES]

A QUICK GOOGLE SEARCH OF "Leadership" will come up with more than 50 million results. Yet in spite of all the learned articles, books and research, it is still done badly. From governments to corner shops, problems are caused, opportunities missed and ultimately inefficient results come from poor leadership.

Dentistry is no exception. My experience as a coach has shown me leadership styles that vary from the autocratic, "My way or the highway!" right through to the submissive, "the meek will inherit the earth –if the others don't mind".

I think that one of the main problems is that leadership is perceived as a thing that can be learned from a book, that a style can be copied slavishly and that by doing what appears to work for someone else will succeed for you. Difficulties arise when there is no variation in style, resulting in little or no flexibility.

In fact, there are many styles of leadership and it is important to use the most appropriate in any given situation. Writing in the *Harvard Business Review,* Daniel Goleman quotes the work of Hay/McBer who liken the leadership skills required for success to the different clubs in a golf pro's bag. As the pro goes around a course they choose the most appropriate club for the shot. Sometimes they need to ponder the shot, but usually the choice is automatic and that's how good leaders work.

The six styles and their brief statements are:

Coercive leaders who demand immediate compliance. "Do what I say."

Authoritative leaders who mobilise people toward a vision. "Come with me."

Affiliative leaders who create emotional bonds and harmony. "People come first."

Democratic leaders who build consensus through participation. "What do you think?"

Pacesetting leaders who expect excellence and self-direction. "Do as I do, now."

Coaching leaders who develop people for the future. "Try this."

The most successful leaders are those who acknowledge that they are lacking in some areas and work hard at developing themselves. They have analysed their style or styles, observed what works for others, considered their approach and evolved how they lead into something that is appropriate for the situation, the individuals and the challenges that they or the business generally are facing.

In order to succeed, Goleman tells us, we need to have highly developed "Emotional Intelligence". This he defines as the ability to manage ourselves and our relationships effectively. He describes the four fundamental capabilities as self-awareness, self-management, social awareness, and social skill. Each capability, in turn, is composed of specific sets of competencies.

> "LEADERS SET THE TONE, ESTABLISH AND MAINTAIN THE CULTURE AND ARE THE VISIBLE SIGNS OF A BUSINESS'S CORE VALUES"

In any organisation, large or small, it is important that those "at the top" develop leadership qualities in everyone within the group.

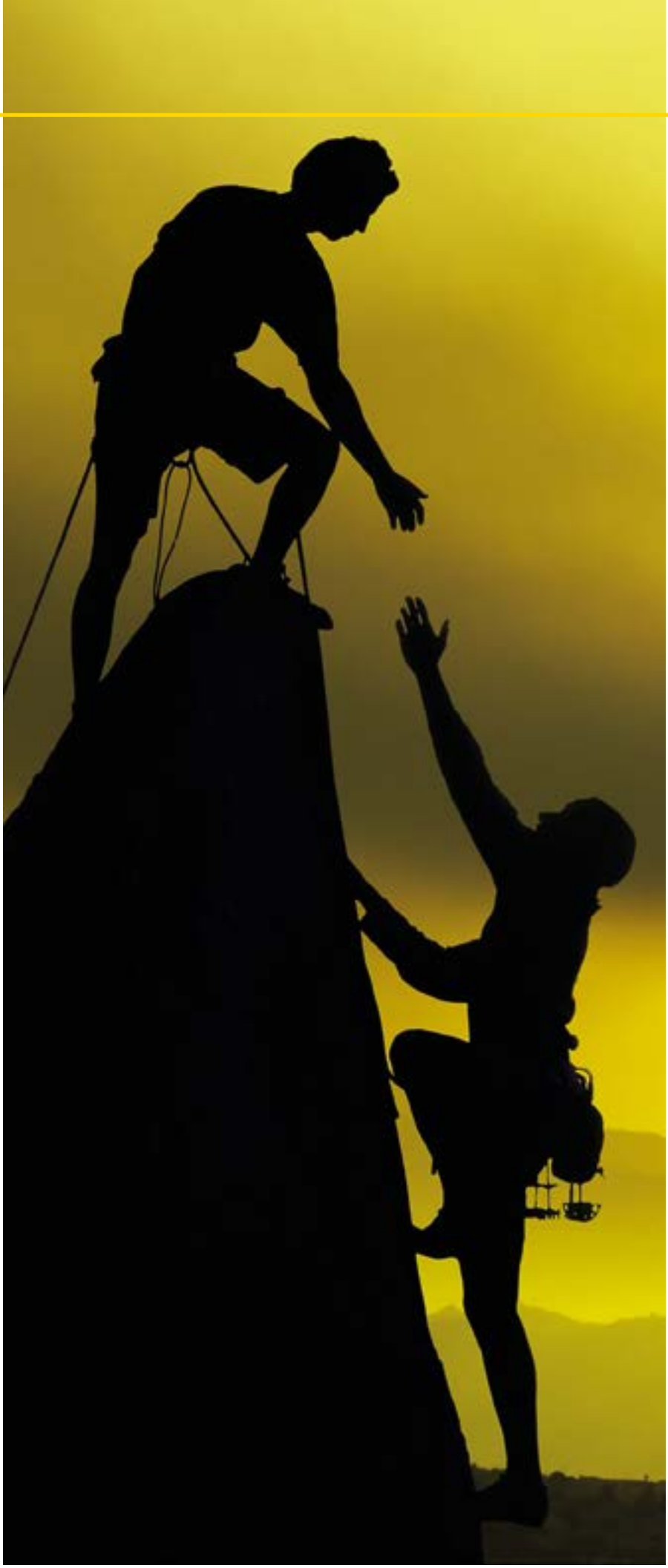
This does not result, as some resistant dental practice owners have told me, in too many chiefs and not enough Indians, rather it grows within individuals a sense of self and responsibility. It is a role of leaders to identify the traits in others that can be developed and also those that are absent or dormant and should be awakened. Every individual needs to have the knowledge of themselves to understand their role or roles and appreciate the roles of other team members.

Leaders in any organisation set the tone, establish and maintain the culture and are visible signs of the business's core values. This is easy to forget – especially when new to a job and the temptation to take the path of least resistance and let standards slip can be attractive.

My experience has shown me that many problems in dentistry communication, discipline, and effectiveness arise from the standard bearers of the leadership letting themselves slide into bad habits. Successful people have successful habits, Dan Sullivan tells us, and there is a need for everyone to say, "It's showtime!" to themselves every morning.

Roger Levin recently wrote of the four bad habits that undermine leaders in dentistry and I can only agree.

1) Procrastination – the urge to put off



relatively small things can be tempting, especially in a busy practice. Yet the small things grow into big ones, and will weigh you down if there is not a timetable and a deadline for dealing with them.

2) Impulsiveness – team members hate the announcements that start, "we're going to make a few changes". People need to understand the reasons for change, the benefits for them and want to feel consulted. Railroading through a change in policy, procedure or protocols will only provoke resistance and promote unease.

3) Complacency – everything changes. Acknowledge it, be aware of your own comfort zone and know how you resist new ideas. The late adopters and laggards in any walk of life are usually left wondering what happened as their businesses struggle and are left behind.

4) Not sticking to your word – your team members rely on you to do what you have said that you will. Failure to complete or to follow through means you have broken your bond and let them down. If you cannot be trusted how can you expect to get the best from them? Consistency is everything.

Alun K Rees BDS is The Dental Business Coach. An experienced dental practice owner who changed career he now works as a coach, consultant, trouble-shooter, analyst, writer and broadcaster. He brings the wisdom gained from his and others' successes to help his clients achieve the rewards their work and dedication deserve.

www.thedentalbusinesscoach.com

HOW TO STOP A PRACTICE MEETING BEING A TOTAL WASTE OF TIME

Being unprepared and having haphazard, unproductive gatherings of your team can cost you dear. What's on your agenda?

[WORDS: RICHARD PEARCE]

HAVE YOU EVER WORKED OUT THE cost of stopping production in your practice for one hour and having all staff attend a meeting? Let's consider a three-chair practice (so three dentists who gross £150/hour and three nurses, two receptionists on £10/hour and a PM on £15/hour).

That's, £450 in 'lost' treatment time and £65 in staff costs. This should concentrate our minds that we had better make very good use of this 'face time' with all the staff.

How many practice meetings have an agenda, produce minutes at the end with actionable steps and everyone leaves feeling motivated and understanding what changes/improvements will directly flow from the meeting? Very few, I would suggest. Many organisations have now realised how wasteful a meeting can be and do things such as make it a 'standing only' meeting. This is supposed to make it sufficiently uncomfortable that no-one wants it to last too long and so only make meaningful contributions!

However, the best practices (in my experience) have learnt how to hold regular, productive meetings. This article aims to explain how you too could realise this outcome.

Many businesses hold board meetings. Normally, they are held to allow non-executives (representing shareholders), to engage with executives in the business. They review performance, they help shape strategy, they hold people to account and most importantly they want implementation. There is no reason why a practice cannot follow this 'model' and if done well, will have a positive impact on practice performance.

A key element of a board meeting is the attendance by individuals who do not work in the business on a day-to-day basis. Practices easily suffer from 'group think'. It becomes accepted that: this or that won't work, he or she won't accept/do this, this is the way we've always done this/why change. Having an 'external' board member can be difficult for a practice to engineer, but that's perhaps where a dental business consultant could be useful (I would say that wouldn't I?)

WHAT ARE THE STEPS NEEDED TO ENSURE POSITIVE OUTCOMES?

Have the right people there. The principal, PM and business consultant works for many. Short slots are given for the lead nurse, head receptionist and compliance manager to join the meeting and present a short report on progress, issues that they have and future actions they are implementing.

> "PRACTICES EASILY SUFFER FROM 'GROUP THINK'. IT BECOMES ACCEPTED THAT 'THIS WON'T WORK', 'THIS IS THE WAY WE HAVE ALWAYS DONE THIS' "

Get the timing right. Second Tuesday of the month, 11-1pm, with lunch provided (and some slippage time into the lunch period), works for some. This also gives time for the monthly report to be completed, for the previous month.

Get the meeting pack out in advance of the meeting (say three working days before). This allows everyone to read what's happened and have questions/thoughts/suggestions ready. Small suggestion – have the financials on yellow paper. You will

definitely want the monthly and quarterly P&L available, so make sure everyone can find it.

Have the agenda at the front – here is a suggestion:

- Minutes of last meeting with action points
- Financials – P&L, balance sheet
- Operational Report – average daily yields (ADYs) for each clinician, new patients (source and by clinician), FTAs, treatment conversion rates
- Compliance
- HR – staffing, recruitment, training, disciplinary
- Marketing – what worked, what didn't, how much each cost, what's planned, input required
- Equipment/IT/premises
- Reception – Head receptionist report
- Clinical – Lead nurse report
- Any other business.

CONDUCT OF THE MEETING

A 'chairman' is a good idea. A degree of formality helps. Practices, to varying degrees, struggle to implement. Having to explain to a meeting why an action hasn't been completed can concentrate minds and force action.

The agreed actions must be written down and who will action, clearly identified. Actions must have 'complete by' dates. This allows you to see how effectively actions are implemented.

WAFFLE AND TWADDLE

Be specific about an action. "We should certainly look at our prices", is pointless waffle.

"A competitor pricing review of three practices will be completed by 20 July with our own analysis of gross margin on treatment codes. Then a proposed new price list will be provided for the next meeting, by Jayne, the PM, having discussed it with the principal, one week before the meeting" is more specific.

MINUTES

As short as possible, with actions by who, highlighted and within two days of the meeting. Minutes are crucial and without them the content and actions from the meeting will be largely forgotten.

In conclusion, the most successful practices know that meetings can be a total waste of time. Therefore, they prepare, have structure, have the right people there (even if only for a short time) and want to see actions and results flow from them. If you want an external representative on your 'board', just give me a call.

Richard Pearce lives in Northern Ireland. Following a business career in various sectors and an MBA, he joined his dentist wife in dentistry. Richard combines his wide commercial experience with being attuned to what it is like for an associate dentist, a practice owner and a practice manager. His unique perspective ensures he can assist a practice owner with every area of the practice to create a more profitable practice and to achieve their smart objectives.

MDDUS CASE STUDY:

A DISPUTED EXTRACTION

A damages claim underscores the importance of keeping records of all treatments given and what options were discussed with the patient

[WORDS: AUBREY CRAIG]

DAY ONE

Mrs S attends her dentist, Mr G, complaining of considerable pain in her upper left 6 molar. Mr G takes a radiograph, vitality tests the tooth and diagnoses an infection. Treatment options are discussed but the patient is adamant she wants the tooth removed. Antibiotics are prescribed due to the presence of a buccal swelling and a review appointment is arranged.

DAY 10

Mrs S returns to Mr G with continuing pain in her UL6 and little, if any, resolution of the swelling. Mr G prescribes a further course of antibiotics and advises a hot salt water mouthwash. He schedules a follow-up appointment for the following week.

DAY 14

The pain in UL6 worsens, but when Mrs S attends her practice she finds it is closed. She knows there is another dental practice nearby and attends there, requesting an emergency appointment. She sees Mr R and tells him she is in a lot of pain, but fails to mention the treatment she has recently received from Mr G. Mr R examines the tooth and recommends immediate extraction. He administers anaesthetic and asks Mrs S to return to the waiting room until it takes effect.

When she returns, Mr R removes the tooth, but not without some trouble as the molar fractures halfway through. He eventually completes the extraction and Mrs S is sent home with post-operative instructions on how to minimise complications and aid healing.

LATER THAT DAY

The pain worsens and Mrs S experiences some bleeding. She seeks treatment at her local dental hospital where small fragments of bone are removed from the socket. She states that she is unhappy with the care provided by Mr R.

ONE YEAR LATER

Mr R receives a letter of claim from solicitors representing Mrs S. It alleges that Mr R's treatment was negligent in that he failed to carry out any investigation (i.e. radiographs or vitality testing) to determine the cause of the pain.

It is claimed he also did not sufficiently examine the tooth to see if alternative treatment options were available and failed to sufficiently numb her mouth before extraction. Bone fragments were left in the socket, a flap of skin was left loose next to the extraction site and the patient was sent home while still bleeding heavily. Because of the lack of investigation, it is alleged the extraction was carried out without informed consent.

Mrs S is seeking damages for avoidable pain and suffering and claims she would have chosen an alternative treatment had it been offered.

MDDUS advisers and solicitors review the claim and commission an expert report. Having consulted dental records from Mr G, Mr R and the dental hospital, the expert is largely supportive of Mr R's treatment, although his recordkeeping is poor. The expert believes the extraction was most likely justified as both Mr G and Mr R agreed that it was indicated. In light of this, the expert believes consent was informed.

However, there is no note showing the extent to which Mr R examined the tooth and whether he had discussed other treatment options with Mrs S.

The dental hospital notes support the claim that bone fragments were left in the socket, but not that there was heavy bleeding, nor a loose flap of skin following Mr R's extraction. Mr R refutes the claim that the patient's mouth was not sufficiently numbed and states that she would only have been sent home once the bleeding had stopped. He said the patient had made no mention of wanting to save the tooth and seemed happy to proceed with extraction. However, there are no notes to support this.

While the extraction did appear to be justified, due to Mr R's poor recordkeeping and apparent lack of investigation, MDDUS believes the case could be difficult to defend in court. The matter is closed with a small settlement.

KEY POINTS

- Ensure full and contemporaneous records are kept of the treatment given and of discussions with patients.
- Consider all alternative treatment options and discuss these with patients to ensure consent is valid.

Aubrey Craig is head of dental division at MDDUS

We have a licence to kill.

With our large fully virucidal product range.

Evil viruses, bacteria, and fungi don't stand a chance against the fully virucidal products of Dürr System-Hygiene. When it comes to manual instrument preparation and surface disinfection, a total of six products reliably work against all enveloped and non-enveloped viruses*, bacteria, and fungi – while remaining really gentle on materials. Short exposure times and long holding times ensure added cost-effectiveness. **More at www.duerrdental.com**

DÜRR DENTAL

*Federal Health Bulletin – Health Research Health Protection1-2004, S. 62

WHITER. BRIGHTER. YOU.

TAKE-HOME AND IN-OFFICE TEETH WHITENING

CREATED BY SDI
POLA
TOOTH WHITENING

POLA OFFICE+

- Can be used with or without a light
- 6% hydrogen peroxide
- In-surgery whitening
- Auto-mix syringe - apply directly to the tooth
- Extra soothing formulation for maximum comfort
- Contains potassium nitrate to inhibit sensitivity
- Sticky gel formula maximises adhesion
- Fast and simple to use: 3 x 15 minute applications

POLA DAY

HYDROGEN PEROXIDE BASED ADVANCED TRAY TOOTH WHITENING SYSTEM

- High water content
- From 45 minutes once a day
- Contains fluoride
- Available in 3% and 6% hydrogen peroxide

POLA NIGHT

CARBAMIDE PEROXIDE BASED ADVANCED TRAY TOOTH WHITENING SYSTEM

- High water content
- From 90 minutes once a day
- Contains fluoride
- Available in 10% and 16% carbamide peroxide
- Neutral pH and desensitising additives

POLA LUMINATE

BRUSH ON & GO!

- No trays required - quick and easy professional brush on tooth whitener
- 6% hydrogen peroxide, low viscosity fast drying gel
- Apply twice a day for just 30 minutes
- Over 60 applications in a 5.5mL tube
- Contains fluoride to assist with remineralisation and reduce sensitivity
- Long lasting spearmint flavour
- Fits easily into a pocket or handbag

SDI Dental Limited
ph. 00 800 022 55 734
WWW.SDI.COM.AU
WWW.POLAWHITE.COM.AU

Lesley McKenzie
Sales Manager Scotland and Ireland
M: 07887930923
Lesley.McKenzie@sdi.com.au

YOUR SMILE. OUR VISION.

SCOTTISH DENTAL

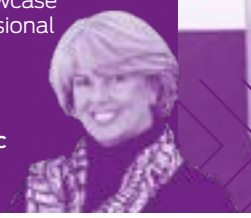
PROFESSIONAL FOCUS

Professional Focus is a brand-new section of Scottish Dental Magazine for all those involved in the business of dentistry. It's the ideal opportunity for you to showcase your products and services and share what your business has to offer. You can use your sponsored content to highlight:

› Exciting new products and services
› Business updates
› Offers and Promotions
› News and developments
› Business-led information and tips
› Your business expertise

If you would like to showcase your business in Professional Focus then contact:

Ann Craib
0141 560 3021
ann@connectmedia.cc



VERMILION – THE SMILE EXPERTS

For patients and staff alike, nothing has been overlooked in creation of the renowned clinic's newest branch in Kelso, which offers the highest quality services in a scenic location that arouses a sense of calm and relaxation

The tranquil setting and the welcoming and comfortable facilities offered by Vermilion's new clinic in the Scottish Borders are bound to put a smile on anybody's face.

Vermilion, a well-established, private 100 per cent referral-only clinic, first opened in Edinburgh in June 2011, and in May 2018 the Kelso branch opened its doors.

Owned by David Offord, a specialist in oral surgery, Vermilion offers, through its large and experienced team, a wide range of advanced treatments including dental implants, restorative dentistry, "All-on-4", orthodontics, periodontics and dental hygiene, endodontics, oral surgery, implant maintenance and conscious sedation.

Both sites share a set of values that are centred around delivering consistent clinical excellence with outstanding service to patients and their referring dentists.

We talked to David about the clinic's expansion into the Scottish Borders.

WHO WORKS AT VERMILION KELSO?

We have a highly experienced team in place at Vermilion Kelso. Most of the dental team at Kelso also work in the Edinburgh clinic, so patients can be assured of consistent clinical excellence. Dr Verena Toedtling (GDC reg no. 113501) is a specialist in oral surgery who works between our Kelso and Edinburgh sites. We have two specialists in prosthodontics who are well known within the dental community: Dr Alfred Dellow (GDC reg no. 51007) and Dr Grant Mathieson (GDC reg no. 65342) who has worked at Vermilion from the outset. Other team members include Dr Luz Garcia-Ford (GDC reg no. 201868) the maintenance dentist, Michaela Zilinska (GDC reg no. 206867), our dental hygienist, and Dr Neil Hallos (GDC reg no. 56120), practice limited to endodontics, who joins Vermilion to look after patients referred to Kelso for endodontic treatment. I base myself between both clinics.

WHAT PROMPTED YOU TO OPEN THE PRACTICE IN KELSO?

Over the past five years we have established an excellent reputation with Borders dentists, and we noted an increasing number of patients travelling to Vermilion in Edinburgh to receive specialist dental procedures. It made sense to open a branch in the Borders, meaning significantly less travel time and ease of access for many patients. In Kelso, we also welcome patients from Northumberland.

IWT are proud to have been appointed provider of IT, Audio Visual, dental chairs and dental cabinetry for Vermilion – The Smile Experts new clinic located in Kelso. **We would like to take this opportunity to wish the teams at Vermilion every success for the future.**

iwt
DENTAL + SERVICES

Turnkey Surgery Installations

Surgery strip-out

All plumbing and electrical works

Chair and dental cabinetry installation

Flooring and final decoration

IT, imaging and Audio Visual

Speak to us today **0845 200 2219**

info@iwtdental.co.uk www.iwtdental.co.uk

STERN WEBER

CASTELLINI

VERMILION

The Smile Experts

Private dental referral clinics with sites in Edinburgh and Kelso. Patients are referred to Vermilion by their general dental practitioner for a wide range of advanced dental treatments including dental implants, "All-on-4", orthodontics, periodontics & dental hygiene, endodontics and oral surgery.

Edinburgh services /

- Dental Implants
- "All-on-4"
- Conscious Sedation
- Oral Surgery
- Orthodontics
- Endodontics
- Periodontics
- Dental Hygiene
- Cognitive Behavioural Therapy

Please call our Edinburgh team on 0131 334 1802 or email smile@vermilion.co.uk

Vermilion
The Smile Experts Ltd.
24 St John's Road, Costorphine,
Edinburgh EH12 6NZ

Kelso services /

- Dental Implants
- "All on 4"
- Oral Surgery
- Endodontics
- Dental Hygiene
- Anti-snoring devices

Please call our Kelso team on 01573 407 007 or email kelso@vermilion.co.uk

Vermilion
The Smile Experts Ltd.
Pinnaclehill Industrial Estate
Kelso TD5 8DW

Refer quickly and securely on vermilion.co.uk/make-a-referral

WHY DID YOU CHOOSE THIS SETTING?

The Kelso site was selected following extensive research and stood out for its strategic location and ample parking space for patients, assuring ease of accessibility. We also wanted to create a rural setting that would evoke a sense of relaxation and calm and offer scenic views for our patients and our team members to enjoy.

WHICH COMPANIES DID YOU WORK WITH?

The Kelso clinic was built from the ground up. We engaged with suppliers with local, expert knowledge to design and build the clinic, including Galashiels-based architect Camerons in conjunction with Berwick builder Cruickshanks & Co Ltd.

On the dental side, we worked with IWDental+Services across many of the services such as IT, telecoms, dental chairs and cabinetry. We also worked with Dental Directory, NSK, Modwood UK and Systems for Dentists, who provided practice management software. We commissioned Kenny Hanley to create another bespoke sofa for Vermilion Kelso, having created the now iconic sofa in our Edinburgh waiting room, which is always a talking point for patients.

DID YOU REQUIRE ANY PLANNING PERMISSION OR FINANCE?

We had a solid trading history from Vermilion Edinburgh,which was very useful. On the business planning side, we worked closely with our accountant Derek Bond at Bond Accountancy. Gail Cormack from Braemar Finance was wonderful as ever, first-class service. The planning side of our Kelso building did take much longer than we anticipated, but we got there in the end!

HOW DID THESE COMPANIES ADD VALUE TO YOUR IDEAS FOR THE PRACTICE?

We were very keen to keep economic benefit within the Scottish Borders as much as possible which is why we mainly engaged with local suppliers on the building side. Camerons Architects have excellent connections within

Scottish Borders Council. It was also invaluable working with a local builder who was able to pull in local resource as and when required.

In the end, our new venture has created nine local jobs. We are also reaching out to dentists in Northumberland, therefore attracting new business into the Scottish Borders. We are very proud of what we have done to create a new business that is bringing positive results into the area. Our patients and referring colleagues are giving us good feedback so that is very satisfying.

HOW LONG DID THE PROJECT TAKE?

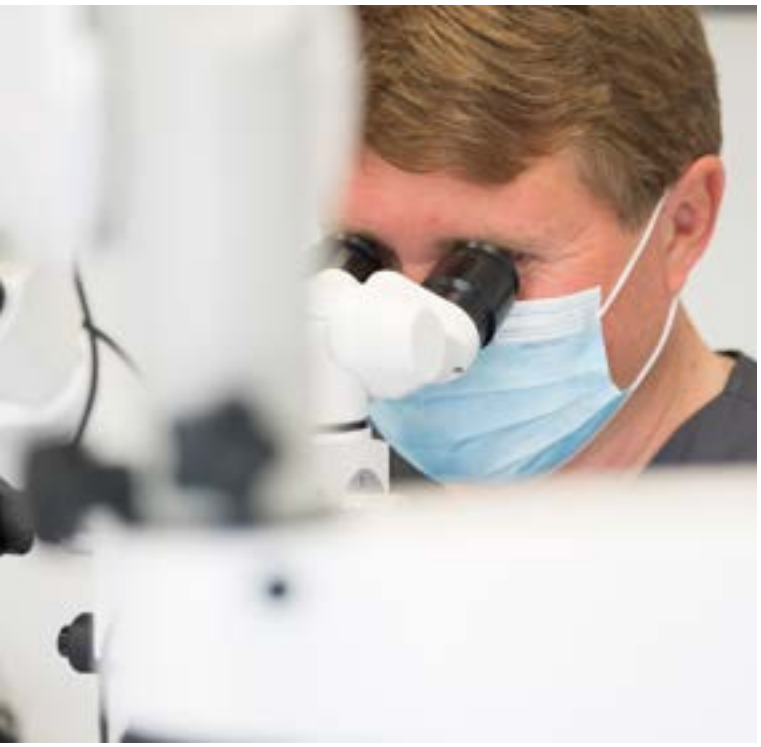
The whole process took three years from start to finish: from finding the perfect location, to drawing up the plans, refining them, obtaining planning permission and finally building the clinic. I guess this seems a long time, but the process has resulted in a stunning clinic that works perfectly for our needs.

ARE YOU STILL USING ANY OF THE SUPPORT SERVICES YOU USED?

Yes, we retain IWDental+Systems for IT and telecoms services within both our clinics. We also have ongoing relations with our dental suppliers with whom we liaise on a day-to-day basis.

WHAT SORT OF TRAINING DO YOU PROVIDE FOR YOUR STAFF

Our dentists are experts in their field, with the majority being specialists. They have all gone through rigorous training and many of them are teaching the next generation of dentists at dental school. Many of our clinicians examine for the Royal College of Surgeons of Edinburgh or at the University of Glasgow. They are committed to attending courses and conferences across the world to ensure they are up-to-date with the fast-moving world of dentistry, particularly on the digital and technology side. Every morning we sit down as a clinical team to discuss the day's cases and treatment plans.



Our support team, including our dental nurses and administration team, are all encouraged to constantly improve their knowledge and skill set, and all benefit from training to ensure they have the necessary skills to carry out their job. For the dental nursing team, full training is given within dental implants and restorative dentistry and all have the opportunity to develop their skills in a professional learning environment. We also conduct regular training on a day-to-day basis outlining policies and procedures with new nurses and staff. We also get together at least once a year as a group to revisit best practice and conduct team-building exercises.

ARE THERE ANY FACILITIES SPECIFICALLY DESIGNED TO ENHANCE THE EXPERIENCE OF YOUR PATIENTS – AND YOUR TEAM?

We place the highest emphasis on customer care, and we ensure each and every patient feels at ease when they arrive. Our waiting rooms have been designed to feel high quality without compromising comfort. In Kelso, the waiting room (along with the surgeries) has stunning views of the rolling fields.

The Kelso clinic has three surgeries (Edinburgh has five), decontamination unit and dental laboratory. We have also invested heavily in technology to ease the patient's dental experience: Kelso has a Sirona XG3D cone beam CT scanner, while in Edinburgh we have a Planmeca ProMax 3D Classic. We invested in the Trios 3Shape intra-oral scanner over two years ago, and prosthodontist Dr Grant Mathieson uses this to take digital impressions for the majority of his cases. We recently acquired a second intra-oral scanner, the Emerald from Planmeca, which links seamlessly with the cone beam scanner.

For our staff, we have made a high level of investment. There are separate staff entrances to ensure staff privacy, personal lockers and changing rooms at each site with shower

facilities. Each site has a staff room with a kitchen, with complimentary tea and coffee-making facilities. Many of our nursing team work on a four-day only weekly rotation and benefit from a "time back" scheme.

HOW WOULD YOU DESCRIBE THE ETHOS OF THE PRACTICE AND ITS APPROACH TO PATIENTS AND EMPLOYEES?

At Vermilion, the values are centred around delivering consistent clinical excellence with outstanding service to patients and their referring dentists. We are 100 per cent referral only, and after treatment at Vermilion all patients are returned to their own dentist for their ongoing dental care.

Vermilion is also known for its popular CPD events for its referring dentists that are held both at the clinics and off site.

For our employees, it is our aim to offer our team a stimulating and dynamic workplace that is constantly challenging yet encouraging to enable them to learn and progress. Our success comes down to the strength of our team, pulling together and always putting the patient first. We have a huge amount of pride in our team and our greatest pleasure is seeing them flourish and do well.

WHAT HAVE BEEN THE PERSONAL CHALLENGES OF TAKING ON THIS PRACTICE?

We take a pride in our transparent communication with patients and their referring dentist, and we are currently undertaking a huge administrative audit to ensure that we are constantly thinking and pushing ourselves to improve what we do.

HOW DO YOU SEE THE FUTURE FOR THE PRACTICE?

Don't lose sight of what we do best and stick to doing that well.

www.vermilion.co.uk/make-a-referral

'THE ONLY THING THAT IS CONSTANT IS CHANGE'

Greek philosopher Heraclitus's observation of 2,000 years ago has never been more true than it is in today's fast-moving world. Systems for Dentists is keeping pace at the forefront of incessant innovation

In a world of increased patient choice, instant communication and population mobility, failure to change often leads to a reduction in business revenue. The digital age has pushed the boundaries of features that businesses can expect from their management systems; this is especially true in the ever-evolving landscape of dentistry.

Modern software is never truly finished, the best software companies regularly interface with their clients and in turn update and enrich their offerings to meet the ever-growing demands of their customers' business and clinical requirements.

Systems for Dentists' flagship Dental Practice Management Software is an exceptional example of agile software development. Designed around its client base the software evolves through direct input from the professionals constituting their userbase.

Featured in the previous article, Vermilion – The Smile Experts had become despondent with their previous software supplier. Having once been recognised as a market leader for innovation, their previous supplier had left it too long to update their software to the needs of a modern practice. This resulted in the team at Vermilion having to find more and more methods of working around daily processes.

Change may be a universal constant, however it is rarely attractive if your team is working to a perceived efficiency. Unfortunately, lost opportunities caused by limited functionality are often not identified. Mediocre, disparate solutions may meet the immediate needs of the business, but this false comfort often causes more harm than good.

Over the past few years Systems for Dentists has been leading the way in Scotland with regards to the NHS eDental programme. It is delighted to be the first software supplier to complete the first two phases and to have been the first to commit to the eOrtho project. Simply striving to be the first and best for eDental is not enough. Systems for Dentists is enabling both NHS and private orthodontal practices to manage the entire workflow of referrals and clinical management in this complex and interesting specialist sector of the industry.

Good-quality development of complex new features can be time-consuming, ensuring the features are mapped out correctly, tested thoroughly and the maximum benefit is delivered to all clients. Through agile development techniques and a true partnership with clients, Systems for Dentists has been able to innovate by implementing some truly exceptional features and improvements in a remarkably short period.

Recent client and industry led developments include features such as:

- Integrated referral pathways with detailed reporting
- Orthodontic charting including IPR, elastics and brackets
- Secure email for patient communications
- Live, secure online booking and document completion system.

Without change there is no innovation, creativity or incentive for improvement. Systems for Dentists recognises this imperative, and it constantly aspires to the continued development of new features to solve the immediate and future challenges of its clients.

For more information regarding Systems for Dentists' cutting-edge Dental Practice Management software or the delivery of eOrtho transmissions in Scotland call their sales team on 0845 643 2828 or visit www.sfd.co

Systems for Dentists

Systems for Dentists provides quality dental practice management software for NHS and private practices. We have been developing high quality, intuitive dental software since 1987.

Our team pride themselves on building strong, long-term relationships with our customers, tailoring the dental software to suit their requirements.

Our service includes:

- Detailed, meaningful reporting system
- Flexible administration options
- Comprehensive user training
- UK customer service

Contact us to **book your demo** and speak to our sales team to discuss your requirements

0845 643 2828

sales@sfd.co

www.sfd.co

NSK

CREATE IT.

iClave plus

More safety, More capacity

NP143/17 Approved

Dolbymedical

your partner in infection control

01786 460600 | dolbymedical.com

BUY

£4,449 + VAT

including delivery, installation & validation*

RRP **£5,481 + VAT**

LEASE

£149.02 + VAT pm

including fully comprehensive maintenance, parts, labour, call outs, annual service, PVI & re-validation*

TRADE IN discount **£532***

Includes **5 FREE** NSK handpieces worth **£2,600***

For more information contact

Angela Glasgow | M: 07525 911006 | E: aglasgow@nsk-uk.com

*Terms and conditions apply. Dolby Medical promotion. E&OE. (TRADE IN DISCOUNT: £532 from HTM2010 installation, validation & delivery). (LEASE: £60 arrangement fee +£60 end of term fee). NSK Handpieces include x3 S-Max optic turbines and x2 FX25m 1:1 contra-angles


Aimee Gibbons, Thorntons Dental Team

THE RIGHT TEAM FOR THE RIGHT SPECIALIST ADVICE

With their in-depth knowledge and understanding of the dental sector, the Thorntons Solicitors team provide a wide range of bespoke services covering all aspects of the profession

We recognise that members of the dental profession have their own specific needs, which are unique to the sector in which they operate. For that reason, Thorntons has a team of lawyers who specialise in advising dental practices, who dentists can be assured will understand the intricacies of the profession.

Our dental team is one of the leading providers of specialist legal advice to dentists across Scotland. In recognition of our specialist knowledge, we are the only Scottish legal firm who are members of both the Association of Specialist Providers to Dentists and the National Association of Specialist Dental Accountants and Lawyers.

Our clients represent a wide range of practice types and each one can be assured of our in-depth knowledge and understanding of the dental sector. We have an experienced team of lawyers, and other professional advisers, who can deliver a flexible service specific to each client's individual needs and requirements. We are able to provide advice in relation to your practice as well as your own personal requirements, such as preparing your will.

The demand for the team's assistance has steadily grown over the years, with the original team of two to three lawyers growing to nine in the last few years. The growth is demonstrated by the team's level of work – in 2017 the team dealt with practice acquisitions and disposals with an aggregate value of more than £25 million.

Michael Royden, Lead Partner in Thorntons Dental Team, said: "The ability to provide bespoke, focused advice to the profession in Scotland has led to the team becoming very well recognised by Scottish dentists, a reputation which we are extremely proud of.

"Many of our team members spend 75-80 per cent of their working week advising dentists on a range of issues, from practice sales and acquisitions, expense sharing and partnership agreements, and associate agreements, to regulatory advice in relation to NHS regulations, which can be very complex in areas."

The Thorntons Dental Team has contacts with dental accountants, valuers/sales agents and with all of the healthcare teams within the Scottish banks, and can call upon advice from them, or make introductions, where required. That allows us to provide a seamless service to our clients, dovetailing with these other professionals when the need arises.

The team is always happy to speak to any dentists who think that they would benefit from our advice, without any cost or commitment on their part.

Of most importance to the team is the level of service provided to our dental clients. Our aim is to be a long-term partner to our clients, with our advice helping them to achieve their long-term goals as well as their short-term objectives. In turn, we recognise that the best form of advertising is word of mouth. We therefore value very highly the testimonials provided by our existing dental clients, which endorse the specialist advice provided by the team in a range of areas, and which we proudly display on the dental page of our website.

* **Pictured:** *Thorntons Dental Team*

Introducing the Thorntons Dental Team

Understanding the unique needs of the Dental profession

The Dental Law Team at Thorntons are on hand to take some of the strain by providing practical and implementable solutions. So, whether you are buying or selling your practice, incorporating it, dealing with associates, handling staff issues, entering into expense sharing agreements, agreeing a partnership, or struggling with regulatory or disciplinary issues Thorntons can help.

For specialist legal advice contact one of the partners in our Dental Law Team:

Michael Royden
mroyden@thorntons-law.co.uk
Tel 01382 229111

Ewan Miller
emiller@thorntons-law.co.uk
Tel 01382 229111

Dental Deals totalling
£25 million
In 2017

@ThorntonsDental
www.thorntons-law.co.uk

Thorntons
SOLICITORS AND ESTATE AGENTS

WRIGHT, JOHNSTON & MACKENZIE LLP FOR ALL YOUR DENTAL PRACTICE NEEDS

Wright, Johnston & Mackenzie's Healthcare team has, over many years, honed its expertise in dealing with the issues which face the dental profession. We give advice which anticipates your needs and is pragmatic, informed and covers all stages in the professional life of a dentist.

SETTING UP AND STRUCTURING A PRACTICE

If you are looking at setting up your own dental practice or joining an existing practice we can help you with everything from advice on the correct structure (incorporating a company, issuing shares, articles of association etc.) to buying or leasing property, bank and other funding, employment or associate contracts and just about anything else you can think of. We regularly advise practices on the best solutions for them in terms of their legal structure and the best means of ensuring that internal regulation and management functions as effectively as possible including through drafting shareholder or partnership agreements which provide a clear basis for management, entry, exit and dispute avoidance/resolution.

ACQUIRING A PRACTICE

If you are expanding your business and want to purchase a dental practice, we have the experience and expertise to assist you from start to finish. We will assist you with everything from the heads of terms stage through to completion including diligence and the purchase and sale documentation. In this we combine our extensive commercial and corporate experience with our specific expertise in the dental sector.

SELLING-UP/RETIRING

Similarly, if you are thinking of selling your practice we can guide you through the process to exit. We will advise you on protecting confidentiality, negotiating terms, dealing with diligence enquiries and disclosure as well as protecting yourself in the most effective ways in relation to the warranties and indemnities you will likely need to give to any purchaser. We have both tax and wealth planning expertise which can be indispensable when you are planning for retirement.

REGULATORY AND DISPUTES

Not everything always goes to plan. Our experienced Conflict Resolution team can guide you through the complexities of disciplinary and regulatory procedures as well as disputes. If you get into difficulties with your partners, shareholders, associates or other employees, we can give you pragmatic and effective advice. We combine our extensive knowledge in these areas with a commercially sensible and realistic approach.

THE OTHER THINGS

A dental practice is no different from any other business. You will from time to time face issues on everything from employment to data protection to property. We have someone in our team to deal with all these eventualities. Our team will do its best to ensure that you are in as strong a position as you can be through detailed sector knowledge and anticipating your needs and requirements.

OUR EXPERIENCE

We act for many dental practices and have a long history of providing clear, commercially focused and pragmatic advice on the issues facing them. We aim to resolve issues before they arise. Our approach is truly Client-centric: we put you at the centre of everything we do.

WHERE TO FIND US

Wright, Johnston & Mackenzie LLP is a full-service, independent Scottish law firm, with a history stretching back more than 160 years. The firm has offices in Glasgow, Edinburgh, Inverness and Dunblane. Further information can be found at wjm.co.uk

Colin Millar is the general secretary of the Glasgow Local Dental Committee and, over many years, has presented to dentists on legal issues affecting their particular sector. He has a clear understanding of the issues facing dentists and offers pragmatic and solutions-based advice. You can contact Colin at cjm@wjm.co.uk or call 0141 248 3434.

MEET THE TEAM

STEWART KING:
SAK@WJM.CO.UK

ANGUS MACLEOD:
AGM@WJM.CO.UK

MARTIN STEPHEN:
MSS@WJM.CO.UK

LIAM ENTWISTLE:
LAE@WJM.CO.UK

JOANNE OCKRIM:
JO@WJM.CO.UK

LAW CENTRED AROUND YOU

Wright, Johnston & Mackenzie LLP is a full-service, independent Scottish law firm, with a history stretching back over 160 years.

LAW FOR **YOUR BUSINESS**

HEALTHCARE SERVICES

Our dedicated team has significant expertise in the healthcare sector and acts for GP Practices, Dentists, Opticians, Pharmacies, Care Homes, veterinary Practices and those who supply products and services into the sector.

WE CAN HELP WITH:

- Set up
- Property
- Funding
- Employment
- Regulatory
- Advising Individuals
- Internal Disputes
- External Disputes
- Dissolutions

For more information or an appointment, email: enquiries@wjm.co.uk

Alternatively visit our website or call one of our offices:

GLASGOW	EDINBURGH	INVERNESS	DUNBLANE
0141 248 3434	0131 524 1500	01463 234445	01786 822296

wjm.co.uk

@WrightJohnston

ARE YOU READY TO OWN A PRACTICE?

With the dental practice sales market remaining buoyant and the banks maintaining a healthy appetite to lend to dentists, 2018 is proving to be a good year so far for transactions.

Why are you buying? Seems like a straightforward question, but you will probably be surprised to hear that a good number of people who begin the process do not actually end up buying. You should set yourself clear objectives as this will provide you with the motivation to get over the hurdles that will come your way throughout the process.

Are you financially ready? The initial purchase is a significant investment alongside the first year running costs and any refits or upgrades to fixtures and fittings you wish to make. Determine your budget early and what cash you will need for working capital and renovations. Knowledge of your own resources from your Accounts and what might be available from a lender will be key to purchase negotiations and paying the right price for the practice. If a property is included in the assets being acquired, then get a surveyor involved too.

What type of practice are you looking to buy? Think about the size and location of the practice. Are you looking to run and work in the practice yourself or are you planning to employ people to manage and run it for you? What level of return do you require? It's best to decide on these factors early as it will ensure that you don't waste time on looking at potential purchases that don't meet your requirements. You will also need to examine the thoroughness of the vendor's valuation model and the credentials of the preparer.

EBITDA is an important ratio to consider if you are thinking of buying a practice as it provides an indication of the practice's financial strength and if it is worth what the seller is asking. It is also a useful measure to compare practices in your search as many of the other factors are not always equal e.g. location, patient-list size etc.

A recent report by Christie & Co noted that the average EBITDA in Scotland is 5.9 for associate led practices and 4.1 for owner operated practices. The former tend to be larger practices >5 chairs with the latter tending to be smaller practices with <5 chairs.

This measure of financial health is calculated by subtracting the practices total expenses from total revenues, before subtracting taxes payable, interest paid on any debt, repayment of loans and any depreciation on the building, fixtures and fittings.

Jayne Clifford
Director, Martin Aitken & Co
email: jfc@maco.co.uk

Get up to speed on the potential hurdles you will face. A lot of this depends on whether the practice-owning company and its share capital is for sale or whether an asset sale is taking place. The latter may include the premises, NHS contract, goodwill, fixtures and fittings, and stock. There are pros and cons to both routes, not least in terms of tax and price, and it is vital that these are clarified as early as possible.

Warranties and indemnities are a typical feature of Sale & Purchase Agreements (SPAs) for dental practices. A warranty may be included stating that there have been no claims against the practice. An indemnity clause often included in SPAs might state that the seller must bear any costs incurred by unresolved litigation against the practice after completion. Your solicitor will seek clarity on both so there are no nasty surprises later on.

If you are ready to buy or sell, get in touch and I'll talk you through the process so that you are fully aware of what's involved, the time it could take and the costs.

There's more on buying and selling practices, managing practice finances and tax advantaging the practice in our Finance, Tax and Business Insights for Dentists on maco.co.uk.

BUYING OR BUYING INTO A DENTAL PRACTICE

Becoming a practice owner is probably one of the biggest challenges, and while success can never be guaranteed, seeking the best professional advice is the only way to ensure that the odds are stacked in your favour. EQ acts for a considerable number of dental practices and we pride ourselves on our understanding of the help and guidance you need in order to see your business flourish.

WHAT ARE YOUR OPTIONS?

- Buy into an existing practice – where you will have the support of experienced partners/principals.
- Take over a practice – with the comfort of an existing patient list and established business processes, but the freedom to make decisions without seeking the approval of other owners.
- Set up a brand new practice – where you can have full control over design of the strategy and ethos, through to the reward of seeing that business grow. However, this is riskier as you begin a business venture with potentially no patients.

Whichever option you might choose, the initial considerations will be similar. Some of which are detailed below.

Diligence work: Before securing any deal it is important to carry out diligence work. This will include numerous visits to the practice, a review of NHS inspection reports, a review and assessment of claims and complaints, and an examination of practice records.

Terms of Deal: When securing a deal, the legal teams will prepare the terms for both parties to agree, including other issues such as exclusivity, deposit and actual offer.

For further information and advice, please contact Louise Grant (louise.grant@eqaccountants.co.uk) or Anna Coff (anna.coff@eqaccountants.co.uk) on 01382 312100

Employees: Another aspect to consider is the transfer of employees. It is important to be aware of the legal regulations when taking over an existing business with employees, and the transfer of existing contracts.

Review: Other considerations will include trading structure, finance requirements, taxation, accounting records, credit control, personal financial affairs and statutory requirements.

We understand that tackling these formalities can be time-consuming, particularly when your time could be better spent on getting the business established. Our dedicated team have years of experience and can help make the journey to becoming a practice owner easier. If you'd like to talk about any aspect of buying a dental practice or would like us to assist you in the process, don't hesitate to contact us.

TAKE THE STRESS OUT OF BUYING A PRACTICE

Selling a dental practice can be a complex process. It is important to appoint an expert to guide you and keep the sale running to schedule

It never ceases to amaze me how much inconsistent and inaccurate advice gets circulated among practice owners who are considering a sale. From practices being undervalued and sold because a sales agent claims that "the buyer pays the fee", to recently seeing agents adopt the "English" methodology to valuing a practice in Scotland and therefore placing a totally unachievable figure on what should be a very sellable practice.

For practice owners who are considering selling, it is imperative that ample time is allocated well in advance of your planned exit date and then enlisting the services of a trusted dental sales specialist.

A recent example is the sale of Dentistry @ No 3 in Dunfermline. The previous owner and principal, Alan Carter established the practice about 40 years ago. Planning his retirement, Mr Carter decided to sell the practice and speaking on the decision, he explained: "After meeting with Paul, I felt that I could trust Christie & Co to accurately value my practice and then market it in the most effective way. The various interested purchasers they put forward all seemed very genuine and I felt that I had Paul's support all along the way, right to the final legal stages and signing. His experience in this market was invaluable to me and very reassuring. I would recommend Christie & Co's services to any dentist considering selling their practice."

Mr Carter's appreciation of having a specialist on hand to keep him informed throughout the process was mirrored by Mark Skimming, an experienced and highly regarded multi-practice owner who purchased the business. Mr Skimming said: "It's always a pleasure dealing with Paul and the work done at Christie & Co. Paul is always clear about the background regarding each sale and has the trust of both parties to intervene successfully when required. I would not hesitate to work with Paul again in the future."

Christie & Co is the only national firm undertaking formal, accredited RICS valuations as well as selling practices, so we have a unique insight into prices that are achieved. We provide confidential, simple and accurate advice for you – the seller, in order to take the hassle out of your practice sale.

To discuss how Christie & Co might help you achieve your future plans, contact Paul Graham, Director – Medical at Christie & Co on 0131 524 3416.

PFM Dental

Sales & Valuations

Dental Sales Agency

Open Market Sales I Body Corporates Sales I Sales to Associates/Partners

95% of NHS practices are sold **without a fee!***

- ✔ Independent Valuations (Goodwill and Equipment)
- ✔ Guidance on increasing the value of the goodwill
- ✔ Experts in Body Corporate Sales
- ✔ Full Marketing of the practice
- ✔ Professional Negotiations
- ✔ Sales Progress Management

What our clients say about us:

"PFM Dental have sold two of my practices with great success. A fantastic service and I wouldn't hesitate to reccomend them."

Ray Ross, Edinburgh

"The service has been fantastic and you truly provided a hand holding service throughout. A must for anyone selling to a Corporate."

Adelle McElrath, Kilmarnock

CONTACT US TO DISCUSS THE SALE OF YOUR PRACTICE

t. 01904 670820 | e. martyn.bradshaw@pfmdental.co.uk | www.pfmdental.co.uk

*PFM Dental have registered "Priority Buyers" who will pay the agency fee in addition to their offer on behalf of our clients. All payments are sent to our client's solicitor and fees are charged as normal

A BRIEF GUIDE TO BUYING A PRACTICE

The purchase of a dental practice can be complex. Jon Drysdale explains the essential elements of the transaction

Here, I break down the apparently daunting business of buying a practice into its principal bite-size (excuse the pun) elements.

FINDING A PRACTICE AND NEGOTIATIONS

Many practices in Scotland sell without going on the open market, so keep your ear to the ground. Be aware that without a third-party intermediary (a sales agent), negotiations in this situation can be problematic and lead to delays.

If you are an associate being offered first refusal on the purchase of the practice in which you work, maintaining a good working relationship during the purchase process can be challenging. Friendly negotiations may turn to frustration, especially once the legal process starts and searching questions are asked of the seller (known as due diligence).

When buying through an agent, take care to present a credible profile as this is crucial to supporting any offer you make. The agent acts for the vendor and will offer their opinion to the vendor of potential buyers based on a number of factors, including how buyers have conducted themselves during the offer process and how sound their financial position is. Be prepared to be asked about your ability to raise the necessary finance and to explain how you will do so.

THE VALUATION

If you are buying through an agent, a valuation of the goodwill and equipment will have been undertaken and form the basis of the asking price. There should be a justification of the valuation within the prospectus. You may wish to instruct your own valuation or get a second opinion. However, be wary of doing so early in the purchase process as a bank is likely to want you to use their panel valuer if you intend to raise finance for the purchase. Similarly, if you intend to purchase the practice *property* the bank will insist on a valuation.

THE FINANCIALS

I advise all purchasers to prepare profit and loss projections for the target practice. This should show the level of profitability you expect after the purchase, accounting for finance costs etc. It is helpful to have a specialist dental accountant prepare these to ensure they include all the relevant details. You may also need such projections to support your finance application.

THE BANK

A variety of banks lend in the dental sector. Most will require a deposit equal to 20 per cent of the goodwill and equipment value and many will lend 100 per cent of the property value. There are banks prepared to lend 100 per cent of the purchase price, although usually not to first-time purchasers and certainly not to support a private practice purchase. NHS practices are perceived as lower risk and therefore banks are more likely to lend up to 90 per cent or more on them.

Expect the (variable) interest rate you pay to be Bank of England base rate plus between 2.5 per cent and 4.0 per cent. Banks stress-test their lending based on a rate as high as 6 per cent – the financial projections you provide should reflect this.

If you are short on deposit cash, you may also be able to offer alternative security such as a residential property, although the value of this will depend on the level of any existing mortgage. In some circumstances, the bank will only offer to lend in conjunction with one of the government lending schemes such as Enterprise Finance Guarantee (EFG). Small businesses supported via EFG pay a 2 per cent annual fee to the government, as a contribution towards the cost of the scheme.

Jon Drysdale is an independent financial adviser for chartered financial planners, PFM Dental, which has offices in Edinburgh and York. Go to www.pfmdental.co.uk

LEASE OR BUY

As previously mentioned, the banks will generally lend 100 per cent on a business property. Leases can be problematic, especially if there is a third-party landlord. The bank will only lend for the term of the lease, so if you are restricted to a short lease the loan term on the goodwill and equipment will reflect this. A short-term loan can increase monthly repayments significantly and may make your finance case harder to justify to the bank and less affordable for you. Lease issues are worth considering early on in the process and appropriate legal advice should be sought.

THE LEGALS

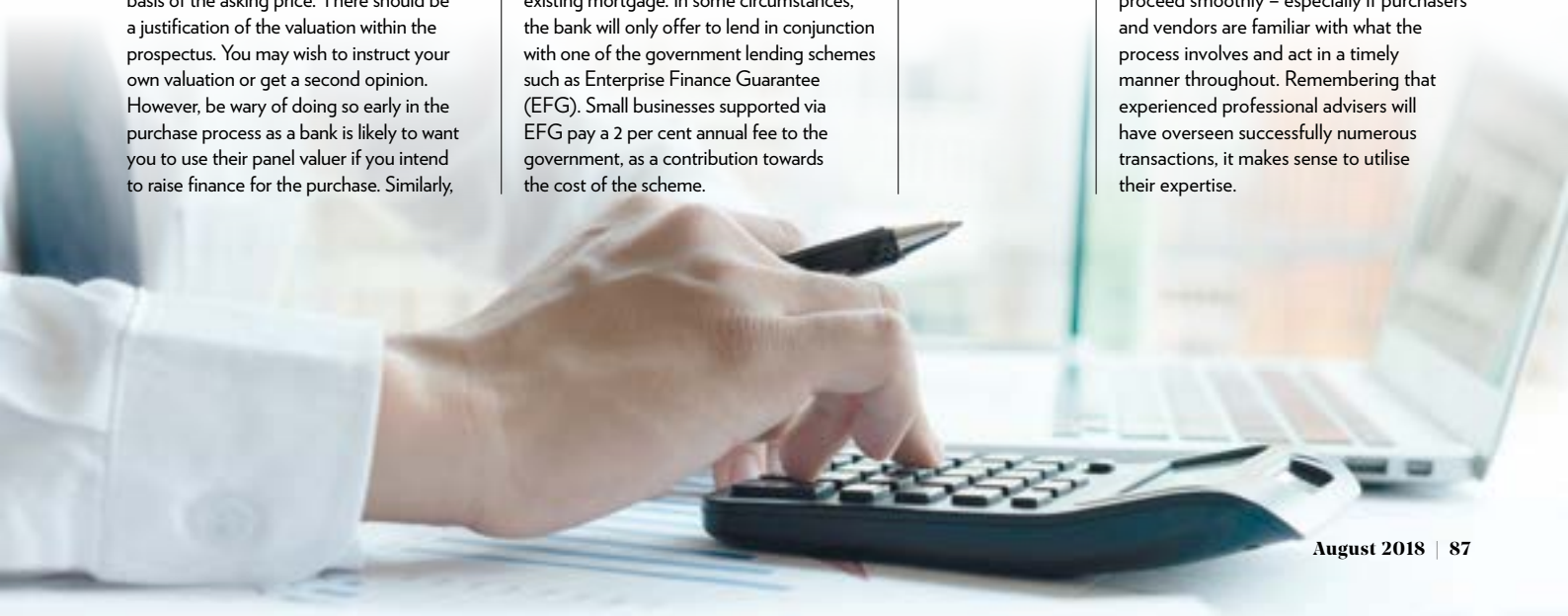
Getting a dental solicitor to handle your purchase is always advisable. Involve them early on to explain the process and to arrange Heads of terms with the vendor. Heads of terms is a document which sets out the terms of a commercial transaction agreed in principle between parties in the course of negotiations.

TRADING STRUCTURE

Transitioning from an associate to practice owner is a good opportunity to review the option to trade as a limited company. This trading structure doesn't work for everyone but may have some tax advantages. Speak to a dental accountant to understand the pros and cons.

SUMMING UP

Most practice purchases (and sales) proceed smoothly – especially if purchasers and vendors are familiar with what the process involves and act in a timely manner throughout. Remembering that experienced professional advisers will have overseen successfully numerous transactions, it makes sense to utilise their expertise.



CRAWFORD WILSON

WHERE PEOPLE COME FIRST

Buying or Selling Your Dental Practice?

FIXED FEE SALE
FREE REGISTRATION

Call us today for a confidential chat

Tel: 07403 109947 **www.crawfordwilson.co.uk**

SCOTTISH INCOME TAX RATES CHALLENGE

Complicated system brings additional burden for self-employed dentists

The 2018/19 tax year will herald the introduction of the much-maligned Scottish rates of income tax and all the added complications that these bring. This is particularly relevant to self-employed dentists resident in Scotland who will now be charged tax at very different rates compared to the rest of the UK.

The Scottish rates of income tax will only apply to non-savings income, and therefore the tax payable on self-employed profits will be affected. Examples of the impact this will have on Scottish taxpayers is as follows:

It can therefore be seen that the introduction of these rates will have a detrimental effect on higher rate taxpayers.

While this transition sound simple enough, the real complications occur where an individual also receives dividends from shares or any other investment income as, you guessed it, these will be taxed at the same rates as the rest of the UK. In some circumstances, a mammoth eight different rates of income tax will have to be considered.

Additionally, Classes 2 & 4 National Insurance contributions will also have to be paid on self-employed profits, and these will remain in line with the rest of the UK.

Within our Specialist Healthcare team, we are perfectly placed to help you negotiate these particular Scottish tax challenges and explore all tax mitigation strategies, including incorporation for self-employed and partnership businesses, in order to narrow the broadening tax gap between Scotland and the rest of the UK.

Blair Hay, Tax Assistant Manager at Anderson Anderson & Brown LLP

Income	Additional Tax from 2017/2018	Additional Tax from Rest of UK
£33,000	£0	£70
£60,000	£184	£924
£90,000	£484	£1,224

Assumes individuals are in receipt of the Personal Allowance

WE TRUST THE SPECIALISTS

Winner - Employer of the Year Award
(Elevator Awards 2018)

- Winner - Employer of the Year Award (Scottish Dental Awards 2018)
- Winner - Best Dental Team (Scottish Dental Awards 2017)
- Best Employer "Highly Commended" (Dentistry Scotland Awards 2017)
- Winner - Health & Wellbeing (Life With Style Awards 2017)
- Winner - Most Improved Practice (Dentistry Scotland Awards 2016)

The Orthodontic Clinic is the only specialist clinic in Aberdeen that has a full time Consultant-trained Orthodontist (Clinical Director, **Dr Lisa Currie**). Lisa has many years of experience in the specialty. She gained her dental degree with honours at Dundee Dental School in 1996 and went on to carry out further training in general practice and in hospital before choosing Orthodontics as her career. She completed her specialist training in 2003, gaining the Membership in Orthodontics from the Royal College of Surgeons of Edinburgh. After further training at Birmingham Dental Hospital, Lisa was accredited as a Consultant Orthodontist in 2006. She held the Consultant Orthodontist post at Borders General Hospital/ Edinburgh Dental Institute from 2006-2011 before moving over fully to specialist practice in Aberdeen.

She has lectured extensively and been very active in training and examining at all levels, including general dentists, undergraduate and postgraduate dental students, as well as dental care professionals. Lisa has been, and continues to be involved in the training of dental students and nurses. Lisa holds an honorary appointment as Senior Clinical Lecturer at the University of Aberdeen.

New patient consultations are COMPLIMENTARY

9 Golden Square Aberdeen AB10 1RB • 01224 611633
www.theorthodonticclinic.co.uk • GDC No. 72073 & 242628

SUPPORTING DENTISTRY IN SCOTLAND

SINCE 1995

Find out why we're Scotland's leading dental plan provider

indepenDent

Your dental care plan provider

01463 223399

garymoore@ident.co.uk

www.ident.co.uk

SCOTTISH CENTRE FOR EXCELLENCE IN DENTISTRY

Always improving services and treatments for dentists and, of course, their patients

The team at SCED are always driving forward innovations, investing in new equipment and introducing additional treatments that they know will benefit referring dentists and also their patients.

The latest two implant treatments that are now on offer at the Centre are Zygomatic and Zirconia implants. Zygomatic implants are usually placed using an immediate loading protocol and avoid grafting and sinus lift procedures. The team at SCED are experienced and qualified to carry out this type of surgery and have seen great results. Zirconia implants are a great alternative to titanium; both are biocompatible and act very favourably with the body. Zirconia implants are tooth coloured and can be technically called 'metal free'. These are great for patients who are opposed to having any metal in their mouths. The addition of these two treatments to the comprehensive range of implant services gives everyone a varied choice of the treatments available.

Courses, seminars and 'Lunch and Learns' are regularly held at SCED and other venues and delivered by the dental team. There is a full programme of courses and update seminars planned throughout the year and it is always a great idea to visit our web site regularly for additional dates – visit www.scottishdentisty.com Did you know... that we also send out a monthly e-newsletter to referring dentists and dentists who are interested in our services? If you would like to be added to our e-list, please email secretary@scottishdentistry.com

SCED's Lunch and Learns take place on a Wednesday lunchtime, and either Arshad Ali or Scot Muir will come to your practice for an hour to update your team about our referral services. This service is completely free.

This is what May Hendry, a referring dentist has to say about SCED: "I have been referring to Scot for several years now and I'm absolutely delighted with the service my patients and I receive from Scot and the team at SCED. Scot is an exceptionally skilled and knowledgeable clinician, and SCED has all the cutting-edge equipment required to provide the patients with a first class service. On top of everything else, Scot is a really personable, nice man and my patients all love him!"

SCED Dental Laboratory is delighted to welcome yet another member to its ever-growing team – Derek Bonnar. Derek has over 40 years of technician experience and has hit the ground running in this busy laboratory. This on-site laboratory now offers a full service from crown/bridge and dental implants through to comprehensive prosthetic services. The latest piece of equipment in the laboratory is the new Straumann P30 rapid-shape printer – the new 3D printer is for high-speed production of maximum-precision and top-quality restorations.

A FIRST CLASS REFERRAL CENTRE

OUR REFERRAL SERVICE INCLUDES:

- IMPLANTS
- ENDODONTICS
- ORAL & FACIAL SURGERY
- CT SCANNING
- ORTHODONTICS
- AESTHETIC DENTISTRY
- PERIODONTICS
- PROSTHODONTICS
- HYPNOTHERAPY
- SEDATION
- ANTI-SNORING DEVICES
- FACE & BODY REJUVENATION
- INMODE™

COURSES & SEMINARS FOR 2018

Throughout the year we will be holding seminars and courses for dentists who refer patients to us.

Visit our website for the 2018 course programme

We are running the Esthetic Alliance Programme in conjunction with Nobel Biocare. Join Scot Muir on the e-learning Smiletube courses

WANT TO KNOW MORE? CALL US ON 0141 427 4530
www.smiletube.tv

FREE SEMINARS

AT SCOTTISH CENTRE FOR EXCELLENCE IN DENTISTRY
6.30PM - 8.00PM

- TREATMENT PLANNING
- REFER AND RESTORE
- IMPLANTS
- ENDODONTICS
- ORAL SURGERY
- ORTHODONTICS
- HYGIENE THERAPY
- NURSE IMPLANT

EMAIL secretary@scottishdentistry.com to book your places

Scottish Centre for Excellence in Dentistry
Watermark Business Park, 335 Govan Road, Glasgow G51 2SE

t 0141 427 4530 **f** 0141 427 6471
e enquiry@scottishdentistry.com
www.scottishdentistry.com

BOUTIQUE DENTAL CLINIC

High-quality implant and cosmetic treatments at Kalyani Dental Lounge

Michael Tang of the Kalyani Dental Lounge in Glasgow has a special interest in aesthetic dental implantology and his clinical practice is almost entirely based on treating patients requiring dental implants. He receives referrals from other dentists for CBCT scans, 3D printing of surgical guides, implant surgery, bone and soft tissue grafting, and sinus lifting.

His interest in dental implantology stemmed from a course held in Harley Street in 2005. In the same year he decided to complete an intensive implantology course in Boston in the US. He has since been lectured to and mentored by some of the leading international clinicians in this field.

After many years of experience in implant dentistry, he decided to formalise his training and has since been awarded the Diploma in 2011 and the Masters qualifications in 2012. With the experience that he has, he is keen to share his knowledge, and for many years he trained newly qualified dentists as well as running teaching sessions with them at Glasgow Dental School. He currently mentors less experienced implant dentists from across Scotland.

In addition, he now runs a course for dentists interested in getting involved with the restoration of dental implants. The course involves both lectures, a hands-on component and includes a mini prosthetics kit to allow delegates to confidently treat patients immediately afterwards. What the delegates like about the course is the free ongoing support provided by his team.

As well as his interest in clinical dentistry and teaching, Michael is also a Dental Practice Inspector in Scotland for the NHS Forth Valley Health Board. He was appointed in 2007 and this current role involves inspecting dental practices and ensuring current guidelines are met.

Michael Tang,
Kalyani Dental Lounge,

0141 331 0722
info@dentalpractice.com

A PARTNERSHIP OF ELITE SERVICES

The collaboration between Dental Elite and renowned advisor Ted Johnston brings together decades of experience to deliver essential business knowledge and market intelligence to practices across Scotland

Ted Johnston is an experienced advisor to dental practices across Scotland, working in the sector for nearly two decades.

Now part of Dental Elite and based out of Glasgow, Ted is well placed to work with principals in the run-up to selling their dental practice, advising them on how to maximise value and continue to grow their businesses if they wish to do so.

The partnership between Dental Elite and Ted couples Ted's experience of working across dental practices in Scotland with the market intelligence and knowledge base from one of the UK's top two active agents. The result is that Dental Elite is now growing its presence in Scotland to meet increasing demand for quality practices across Scotland both in the NHS and Private Sectors.

Due to this longevity within the dental industry, Ted has amassed vast experience and understanding of everything dentistry. Ted fully understands the requirements of dentists and dental business owners and this experience supports his role as the intermediary for a dental purchase or a sale.

Recent changes in the dental provision have seen changes in the purchasing of dental practices. There is a perceived increase in the 'corporate' sector. However, corporate purchases account for only 20 per cent of all transactions; this means there is still fantastic opportunities for dentists to be their own boss. It's an exciting market and an exciting time to be involved.

We are offering a Free Practice Healthcheck / Valuation with Ted. The purpose of the valuation may not be for an imminent sale but aims to give you an insight as to the current value of your business and, moreover, where this value could be improved in the coming years. Given Dental Elite is one of the two busiest agents selling more than 20 per cent of dental practices sold across the UK, we are well placed to give you a 'live' analysis on how volatile your practice valuation is and how this may play into your plans.

The actual Healthcheck will take about an hour of your time and, we are happy to meet you outside working hours; either before or after work so as not to alarm any members of staff. Meeting us does not commit you to anything whatsoever, unlike some of our competitors, and it does not bind you to instructing us to sell your practice.

If you would like to book a valuation or would like more information. Ted's mobile number is 07718490506 or you can email at valuations@dentalelite.co.uk.

"We **sold** our practice with Dental Elite"

Micheal and Lara Hesketh, Exeter

Get your **FREE valuation**

Ranked #1 on Google Organic search for buyers and with an encrypted data room access to ensure all documentation throughout a sale is confidential, Dental Elite really do stand apart from the market.

Contact us today for more information and free of charge valuation

4.8/5 ★★★★★ based on Independent Customer Feedback feefo

DentalElite

01788 545900 | valuations@dentalelite.co.uk | www.dentalelite.co.uk

SEEING IS BELIEVING

Before treatment even starts, New Life Teeth gets patients involved with a re-assuring insight into how implants are created in its digital laboratory

If patients want to check out the cutting-edge digital lab at New Life Teeth in Edinburgh, all they have to do is ask.

That's because the ability to provide an insight into how implants are created was one of the essential features built into the lab and its associated clinics when the premises at Canal Point were developed three years ago.

Duncan Robertson, lead technician, explained: "We wanted to make the lab a showpiece and a little different from the norm." He said patients are surprised when they see the extent of the processes and technology. "They usually respond with 'Oh wow, I didn't realise all this was involved.'"

The lab is distinctive in several ways. It is one of only two in Scotland using Zirkonzahn Prettau, the unique bridge material that can be used to create a full arch without the need for strengthening infrastructure.

It offers a comprehensive service with several stages, including prototypes the patient can use to gauge what the finished bridge will look like.

And, as well as a very strong line-up of in-house surgeons, it has a regular and growing contingent of referring dentists.

"When planning the lab we wanted to keep things as clean as possible, have sufficient space for us to work in and accommodate all our equipment," said Duncan.

"We have a close association with Zirkonzahn who have their own specific design style – we wanted to reflect and emulate that."

GROWING WORKLOAD

New Life Teeth has a practice in Belfast and is linked with the Scottish Denture Clinic, also in Edinburgh. Those sites provide work for Canal Point and its quickly growing workload led to rapid expansion of resources. "We began with one milling machine and realised quickly it was getting overloaded, so we brought in a second," said Duncan.

There have been other additions. The three members of staff – Duncan, fellow technician Anna Kuszel and trainee technician Jade Ritch – are about to be joined by a fourth.

"The team ethos is strong here and we all play our part in helping patients feel valued, which is one of the reasons we give them the chance to look behind the scenes," said Duncan.

The New Life Teeth team give patients the chance to see their cutting-edge technology in action. For further details. email Duncan@ newlifeteethlab.co.uk

Tel: 0131 564 1822
Website: www. newlifeteethlab.co.uk

"Even before surgery starts we look to get patients involved and I see many of them on a one-to-one basis to get a feel for their preferences on colour, shade and shape.

"We always do our very best to give patients exactly what they want – that's the whole point of the process."

The lab produces everything from single crown and bridge cases to full arches – the latter is its area of specialty.

"We use the latest technology, including digital smile, illustrative photography, and regular communication with patients to get that all important final result.

"The feedback we receive from our patients and referring dentists is extremely positive. They think it's incredible that we can do what we do."

And if they don't believe it, they can always see it for themselves.

NEW LIFE TEETH LAB
transforming your smile

Private lab services

At New Life Teeth Lab we look to provide only the highest quality dental restorations in a timely fashion with attentive customer service, and strive to provide the perfect blend of technical expertise, personal service and dependable results. We strongly believe in relationships based on communication and feedback.

We take pride in using only the best restorative systems and consistently invest in the latest technologies to allow us to achieve your ideal results.

- Metal Free Restorations
- Implants
- Lab to Lab
- Prosthetics
- Shade matching
- Crown & Bridge

"We use the digital smile design concept to provide our patients with an idea of the new teeth they could have. We capture this at the beginning of treatment.

This is normally in a 2D image and gives us a nice template to work with to start producing trial set up designs, motivational wax ups, additive chair side mock ups right through to protoype bridges and ultimately the final Prettau bridge.

This is a very useful tool as it helps the patient physically see what their new teeth could look like. It is also a handy tool to communicate with dentists. Visual communication we find is always the best way and the DSD concept gives us that in a straight forward and easy to use format." Duncan Robertson, RDT

DSD
Digital Smile Design

Tel - 0131 564 1822
Address - 22 West Tollcross, Canal Point, Edinburgh EH3 9QW
Website – **www.newlifeteethlab.co.uk**
Email – Duncan@newlifeteethlab.co.uk

BESPOKE SERVICES PUT PATIENT FIRST

OTS Dental's new digital workflow is further enhancing its reputation of delivering a diverse range of high-quality products, especially created and crafted to meet individual needs

OTS Dental is a dental laboratory based in Edinburgh that provides fixed and removable prosthetic and orthodontic appliances to dental practices around the country. We also offer a direct denture service to patients, delivered by clinical dental technician Caroline Kirkpatrick.

At OTS Dental, we construct our dentures with the best-sourced quality materials. Using only the most modern methods, we have installed a digital workflow within our lab, and are working towards becoming an all-digital lab provider.

We are here to help you. As a direct denture provider, we have experience in delivering bespoke denture services to customers in Edinburgh and beyond.

We put patient care first. Visit our Edinburgh practice for a friendly, warm welcome and to find out how we can help. For dental practices, we also offer a technical service, providing a full range of laboratory products. Get in touch to find out more.

We have a new facility set up to provide a direct denture service to patients in a relaxing, comfortable environment, and also have an on-site laboratory facility where we construct dentures.

The new digital workflow we have launched at OTS Dental has given us the ability to produce high quality restorations for dental crowns and bridges. From receiving STL files to sending the final product out, the process is easy and smooth. We use only the highest quality, modern materials for the production of dental crowns and bridges.

OTS DENTAL LABORATORY

Visit us at www.otsdental.co.uk or contact us by emailing info@otsdental.co.uk or calling 0131 652 1857

We provide new Clear Aligners, which offer a more cost-effective orthodontic treatment. Our digital orthodontic service allows us provide digital study models, indirect bracket transfer trays and occlusal 3D print splints. Moving towards new technology and continuing with the conventional techniques offers a more diverse range of orthodontic appliances for your patients.

With more than 24 years of experience in dental technology, Caroline has an in-depth knowledge of her trade, in particular in the field of crafting and creating bespoke, comfortable dentures.

A graduate of the prestigious Edinburgh Dental Institute, she is one of the few clinical dental technicians who have earned their Diploma in Clinical Dental Technology from the Royal College of Surgeons in Edinburgh.

OTS
DENTAL LABORATORY

OTS Dental Laboratory in Edinburgh are now providing clear orthodontic aligners Using new 3Shape scanners and software we can provide clear aligners at a more cost effective price than our competitors.

We can accept digital impressions as well as alginate impressions which can be scanned to provide video assessment and detailed tooth movement reports for you to discuss the treatment with your patient.

Assessments are sent to you via e-mail and when approved to go ahead the case will be delivered to you in 5 working days.

Clear removable aligners are a relatively new way of correcting mild-moderate orthodontic problems in general practice let OTS Dental help you deliver the treatment the patients are requesting.

One arch assessment:	**£40**
One printed arch and aligner:	**£48**
Model with attachment and placement jig:	**£25**

Contact or send intra oral scans to **otsdigitalortho@gmail.com**
or we can pick up in and around the Edinburgh

Call us on 0131 653 1857
or visit us at www.otsdental.co.uk

SOUTHERNIMPLANTS

MACHINED SURFACE CORONAL (MSc)

Machined coronal area

The implants have a specific roughness machined coronal surface area. This "smoother" coronal surface is engineered to reduce bacterial adhesion and thus decreases the risk of infection which could lead to marginal bone loss.

Excellent primary stabilty

The implants feature a tapered body with single start 40° thread, which provides excellent primary stability, especially in soft bone.

Contoured apex

The apex of the implant is specially contoured to minimize the risk of trauma to adjacent anatomies.

Product range extension

There are four new External Hex introductions:

* The Ø3.0mm tapered implant, known as the Piccolo.
* The Ø3.25mm 12° Co-Axis implant.
* The Ø4.0mm 24° Co-Axis implant.
* The MAX Ø6.0mm implant.

Co-Axis™

The unique angulated platform design of the Co-Axis is available in the MSc range. The Ø3.25mm and Ø4mm feature a built in platform angulation of 12°, and a recent addition is the Ø4mm implant with an angulation of 24°. This innovative design enables tilting of the implant without compromising the prosthetic emergence angle in the anterior maxilla. This results in a greater volume of facial soft tissue and facilitates screw-retained prosthetics.

The Co-Axis implants are supplied with a fixture mount and require no special componentry for implantation. The Ø5mm range also features a 36° angulation in addition to the 12° and 24°.

Innovative **Solutions** for Challenging Cases

www.southernimplants.com

THE VISION BEHIND DENTAL LOUPES

Dr Saeid Haghri runs one of the largest dentistry social networks in the UK, Dental Roots. Here he explains the unseen but significant benefits of using dental loupes to get detailed views of your patients

Dental Roots concentrates on education and keeping qualified dentists and dental students in contact. Naturally, we cover many topics, and one that comes up very often is the question of loupes.

We receive a variety question:

1. When should I buy dental loupes?
2. How much should I spend?
3. What magnification should I get?
4. Which company should I go to?

A poll we ran on our platform recently showed that 41.6 per cent of the students use dental loupes, which is very impressive.

I could say that one of the benefits of loupes is that you see better, but I think that is a bit obvious! It is much beyond that.

The use of loupes, in my opinion, is about caring for your patients; if you can't see well, how can you provide them with the best quality of care?

In fact, when signing up associates for our clinics, one of the requirements we have is that they should wear loupes. We all treat our patients to the highest level possible, and if we are to get another dentist on board who could potentially be seeing our patients, they would need to be able to see the same picture!

Loupes are eye openers – literally. When you first start using loupes it hits you – what did you do all the time when you were not wearing loupes? You almost get scared to know how much you did not see.

We all want to do our best for our patients and follow the golden rule: *Do good to others as you would like good to be done to you.*

So if you prefer to see a professional treating you with magnification, there is no reason that you would not do the best for your patients.

EYE OPENER

Patients are very observant. After all, remember that for most of the time that they are in your surgery their mouth is open, which leaves more time for other senses to pick up on everything. They will know if you care for them, and using loupes, in my opinion, and a good make, means you cared to invest in your patients for their wellbeing.

If you asked me for straight advice without going round in circles, which is my style of giving advice, I would say you should never underinvest in your career.

1. Get loupes as soon as you can. If you can in university that's the best idea.
2. Spend enough money to get a good pair of loupes that you would use for many years to avoid extra expense.
3. Get loupes with which you can change the magnification, or at least get one with high enough magnification that will serve you for a few years. For example 3x for check-up, 4x for crown preparations and 5x forendodontics.
4. Choose a company with a good track record, good customer service and good reviews.

Dr Saeid Haghri
Visit www.shades-clinic.com or email saeidhaghri@shades-clinic.com for more information

ABOUT THE AUTHOR

Dr Saeid Haghri is a multiple-award-winning dentist. He is the founder of national organisations and communities such as Dental Roots, Make a Dentist, ToothWise and Future of Dentistry Awards. He has always been closely in contact with the young dentist and dental students to help them with their education.

He owns multiple private practices. Saeid has created a diverse business portfolio, from growing businesses to multi-million pound companies. He is a business course director and motivational speaker, influencing thousands of entrepreuners, and is involved in advising and networking companies and government bodies worldwide.

Experience Interchangeable
Magnification Today!
Orascoptic.com/BDJ

WHY CHOOSE JUST ONE?

Why limit yourself to just one magnification power? With interchangeable telescopes you have the power to select the optimal magnification for each procedure. Offering a range of magnification powers from 2.5x-5.5x, the OmniOptic™ system is your ideal solution for simplified magnification upgrades. A lighter weight option when compared to adjustable magnification loupes, the OmniOptic system gives you a customized comfort from start to finish.

Discover the power of interchangeable magnification today.

OMNIOPTIC™
By ORASCOPTIC™

Contact: Jane Kilgour
Jane.Kilgour@orascoptic.com
Contact : 07811 054941

EXPANSION FOR MC REPAIRS

Maddalena and Carl Wise's mission to offer dental practices throughout the UK the very best in equipment support has been a huge success... and that's good news for customers, as the business goes for growth

MC Repairs Ltd was formed in 2009 by husband-and-wife team Maddalena and Carl Wise. Their vision was to create long-term relationships with practices throughout the UK and help practices to understand how to get the most from their repair bills.

Carefully selected components from around the world ensure repairs stay in practice for the optimum amount of time, and maintenance advice helps to keep equipment in tip-top condition. Customers then benefit over the long term when they see their average spend declining over the years.

Due to their success, the Wises are now about to move their two business brands and the teams to a new state-of-the-art workshop facility and warehouse to further aid the growth and provide even more to the industry.

Carl has now been in the industry 20 years and knows handpieces, scalers, motors, couplings etc. like the back of his hand. All makes and models can be catered for and no particular brand receives priority. The teams at MC are trained to recommend the best options/brands for the practice in question. Talk to anyone on the team and you will be tapping in to a combined knowledge of well over 50 years in the dental industry.

Follow Maddalena and Carl and their team on all of the social media outlets. From tips and news to offers to keep you always up to date, you will not be disappointed Contact 01253 404774 or visit www.mcrepairs.co.uk or www.mcdental.co.uk

MC Repairs Ltd is independently verified to ISO 9001:2015 on an annual basis. Components are selected carefully from around the globe or customers can opt to have only OEM components fitted to their equipment. All quotations are provided totally FREE of charge by using either our FREEPOST repair packaging or arranging a collection online. Equipment repairs are quoted upon receipt and 99 per cent of the time can be returned within 24 hours, as we know you can't be without your instrument for too long.

MC Dental Equipment Ltd is the brand used to showcase the wide range of products the team recommend and have on offer. From handpieces, scalers, motors, implant units, autoclaves, scaler tips, lubrication there is so much to choose from. You can view the complete catalogue online or request a regularly updated offer brochure spotlighting the best offers from the best brands around the world.

MC Repairs LTD

The handpiece specialists

FAST ... RELIABLE ... EXCELLENT VALUE ... FAST ... RELIABLE ... EXCELLENT VALUE ... FAST ... RELIABLE ... EXCEL

SERVICE, REPAIRS, HELP & ADVICE.
WE WON'T BE BEATEN ON SPEED OR PRICE.

- → Free, no obligation quotations
- → Best components used for improved performance
- → All makes and models repaired and serviced
- → Three outstanding service options
- → Maintenance advice for longer life
- → Freepost repair pack service

24 HOUR TURNAROUND

PREMIUM QUALITY COMPONENTS

CERAMIC BEARINGS & 6 MONTHS WARRANTY

ONLY £49.95 + VAT*

HANDPIECES • MOTORS • SCALERS • COUPLINGS • & MORE!

CONTACT US NOW FOR YOUR FREEPOST REPAIR PACK

* Offer applies to high speed handpieces only. Mention this advert in order to claim

01253 404 774 repairs@mcrepairs.co.uk www.mcrepairs.co.uk

DRILLING INTO THE DETAIL

Three essential elements for success in buying a practice

You have found the practice you wish to buy. You have your surveyors' practice goodwill/value of the dental practice. Your accountants have given a positive viability forecast, even after factoring in changes in dental staff following the purchase. In principle, you know the lender will give you the finance needed for the practice. You're keen to get going with the purchase. What next?

To make your purchase a success, you need to have a firm idea not just of the finances, but also of the other foundations of the practice. Like any other business, these must be sound in order for the practice to be built up. Three fundaments stand out: the practice's major contracts, the premises and the employees.

CONTRACTS

The introduction of the new Oral Health Improvement Plan rules in July mean that patient dental-plan financing contracts such as Denplan may become of greater importance to practices. How, though, do the differing finance contracts compare? What are the costs and downsides of entering into such contracts? Equally important are the contract-like regulations that restrict marketing to patients and new patients. Is the practice's existing marketing data compliant with the new GDPR regulations? Are its website terms and conditions and privacy policy sufficient to allow web marketing?

PREMISES

If the practice does not own the practice premises, what is the basis for its occupation? It is surprising how often a practice occupies premises based on inadequate documentation. Yet, in the absence of a proper lease, the practice has no business being in the property and could be evicted at short notice. Alternatively, if a lease does exist, does it impose unacceptable conditions? What exactly are the repair liabilities? Who precisely owns the dental chairs and other equipment screwed into the walls or floor – the owner or the tenant?

MORE INFORMATION
Michael Dewar is a partner at CCW Business Lawyers. For further details visit the dental practice purchase guide on our website (https://ccwlegal.co.uk/resources/buying-dental-practice-guide/) or please do get in touch with us.

EMPLOYEES

Of all compliance issues, transfer of employees in a purchase is among the most complex. You will want to know the terms of the contracts of employment (e.g. salary, holiday entitlement, potential claims) and ensure that TUPE procedural rules are followed where employees' contracts of employment are to transfer to you.

The above are examples as to why these fundamentals are so essential to the success of a practice. Fail to address them before the purchase and, at best, significant management time will be eaten up trying to fix them; at worst, the problems won't go away and the practice has in-built instabilities and liabilities.

Fortunately, most of these issues, if identified early enough, can be resolved before the purchase goes ahead. They are generally also easier to fix before, not after. A good dental practice lawyer familiar with this sector can help achieve genuine value for a purchaser.

A CHANCE TO GROW WITH A COMMUNITY

A rental opportunity for a start-up dental or facial aesthetic practice to thrive alongside regeneration developments in the Maryhill area of Glasgow

Maryhill, one of Glasgow's up and coming areas, is the location of a property that offers rental opportunities for spaces that would be ideal for a dental or facial aesthetic practice.

The four units available through DCR Properties form part of a former Royal Bank of Scotland building. The stand-alone sandstone building has a recently refurbished car park with spaces for 12-15 cars.

The front elevation is used by a well-established hair and beauty salon, with the spaces available to rent unfurnished at the rear of the property.

There will be a separate entrance available on the side elevation, and each unit will have individual video entry handsets. There will be a communal waiting area.

The property is approximately three minutes from the local train station and bus stop with frequent services to the city centre.

Maryhill is part of Glasgow City Council's Transformational Regeneration Area with substantial housing development planned. Maryhill Housing Association has committed to upwards of 300 new houses, while a feasibility study is being carried out for the development of further flats along the Maryhill Road area.

Clyde Property has begun the second phase of its development of houses and flats alongside the River Kelvin and local canal, which are proving very popular given their proximity to the west end of Glasgow and local parks.

Glasgow University Campus is five minutes away and Milngavie and Bearsden is a short drive.

The residential area of Summerston is on the property's doorstep, a mixed tenure of housing with a sound community feel, and there are plans for future development in this much sought-after area.

Properties to rent

Therapy / Treatment space to rent, 1944 Maryhill Road, Glasgow, G20 0EQ

There are four units available, ranging from £180 PW to £200 PW depending on the unit size.
The landlords envisage these units being let either individually or as a whole (if let as one small office, LDU unit may be included).
Shared private car parking for 15 spaces including two disabled. Rental agreed by NHS for market value.

Ideal for new start-up. A minimum of five-year lease would be available. Property is Disabled Compliant.

Contact Donna – Mobile: 07827 019190 | Email: dcrproperties@hotmail.com



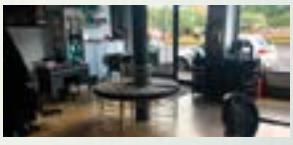

1873 Maryhill Rd, Glasgow, G20 0DE

A short distance from Bearsden and Switchback, this end of Maryhill Road is a busy thoroughfare full of shops and passing trade, a prime location for your business. Property is Disabled Compliant.

Boasting a modern double shopfront, it includes a staff room, two storage spaces and a recently re-tiled bathroom as well as a large open floor space. The shopfront features large windows to attract passing trade.
Ideal for new start-up. Street parking is available. 615ft space. Rental agreed by NHS for market value.

Contact Donna - Mobile: 07827 019190 | Email: dcrproperties@hotmail.com





› ZENDIUM

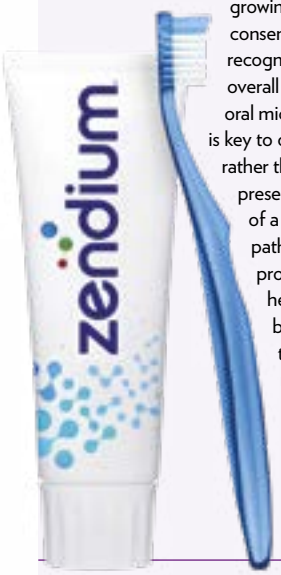
BENEFITS OF A UNIQUE TOOTHPASTE

Zendium is at the forefront of a progressive approach to improving gingival health

At this year's EuroPerio9 congress, Zendium from Unilever showcases a remarkable set of data that demonstrates how daily use of this unique toothpaste improves gingival health by balancing the oral microbiome. Results are perfectly aligned with the evolving view of the pathology of periodontal disease which puts microbial balance, rather than microbial elimination, at its heart.

"In 2017, we published data which showed for the first time how Zendium toothpaste has a positive species-level effect on the oral microbiome," says Dr Mark Edwards, Global R&D Director at Unilever. "Now we build on this with two studies showing the clinical benefit this balancing effect has in the mouth, and specifically on gingival health."

Zendium is a toothpaste that works differently. In addition to fluoride, its unique SLS-free formulation contains natural enzymes and proteins, which boost the natural salivary defences and balance the oral microbiome. A landmark study, published in 2017, showed that over 14 weeks of use, Zendium significantly increased health-associated bacteria and significantly reduced disease-associated bacteria. These findings complement a growing expert consensus that recognises it is the overall balance of the oral microbiome which is key to oral health rather than the simple presence or absence of a specific pathogen. The proven gingival health benefits of balancing the oral microbiome.



To find out more visit www.zendium.com

› CALCIVIS®

INNOVATIVE SYSTEM TO DISPEL FEARS

Interest and engage your patients in a completely unique, and fascinating way. Shift any negative perceptions of dentistry, build rapport, and help patients to realise the benefits of good oral health with the innovative CALCIVIS imaging system.

CALCIVIS is the first biotech product in the world to be used in dentistry: it applies a photoprotein to detect free calcium ions on the tooth surface and captures a glowing, visual map of active demineralisation at the chair side.

CALCIVIS acts as an early detection system that supports preventive and minimally invasive dentistry. It allows dental professionals to identify active demineralisation at its earliest and most reversible stages and provides an extremely effective communication tool that enables practitioners to deliver personalised information to each and every patient.

The CALCIVIS imaging system offers patient-centred education to increase understanding, motivation and reassurance. In this way many of the fears regarding the dental visit can be dispelled to add value and enhance the patient/practitioner relationship.

To discover the benefits that this remarkable technology can offer you and your patients, contact CALCIVIS today.

To find out more visit www.calcivis.com or call 0131 658 5152

› CARESTREAM DENTAL

IMAGE OF A SIMPLE SOLUTION

The CS 7200 imaging plate system is a sophisticated solution designed for maximum simplicity. It enables you to capture images, scan plates and review images without leaving the dental chair. Images produced have a true resolution of 19 lp/mm and they can be viewed on the computer screen within just eight seconds of capture.

Suitable for paediatric, periapical and bitewing examinations, the CS 7200 supports three different plate sizes – 0,1 and 2 – and its compact design ensures it is easy to place anywhere in the practice.

The highly intuitive workflow is complemented by its convenient USB connection and the automatic erasion of plates once finished with. The CS 7200 is one of several Carestream Dental technologies compatible with the CS Adapt module, which offers different filters to suit diagnostic preferences.

Introduce the sophisticated simplicity of the CS 7200 within your practice today!

For more information please contact Carestream Dental on 0800 169 9692 or visit www.carestreamdental.co.uk For all the latest news and updates, follow us on Twitter @ CarestreamDentl and Facebook

› DMG UK

DURABLE CROWNS MADE EASY

Ideally suited for the elderly who do not want to invest in more expensive longer-lasting restorations, patients with a limited budget and children requiring a space maintainer following tooth loss, DMG's new LuxaCrown enables simple, quick and cost-effective chairside fabrication of long-lasting crowns. The result is an incredibly precision-fit, aesthetic and long-lasting restoration which can be worn for up to five years.

In addition to excellent flexural strength, it also possesses outstanding fracture toughness that ensures long-term stability of semi-permanent restorations. Very hard, with a Barcol hardness of 54, in-vitro studies have confirmed its high mechanical strength. Standardised chewing and wear simulations of masticatory behaviour with artificial aging verified a lifespan of up to five years for LuxaCrown.

Its unique indication as a semi-permanent crown and bridge material with outstanding wear allows for a wide range of indications. It can be used to protect the remaining tooth as well as to restore the anatomical form and masticatory function.

For further information contact your local dental dealer or DMG Dental Products (UK) Ltd

› DMG UK

OUTSTANDING CEMENT THAT BLENDS IN

DMG has recently launched a new temporary luting cement which stands out by blending in! TempoCemID is a translucent, dual-cure composite luting cement for temporary luting of all kinds of temporary restorations.

Invisible, but detectable it can be used for temporary and semi-permanent luting of temporary crowns, bridges, inlays and onlays; and temporary luting of temporary veneers. It is also ideal for luting implant-borne restorations.

It is specifically formulated for optimal transparency so that it is invisible underneath a restoration and never impacts upon its shade. This makes it the ideal choice for both posterior and anterior restorations. In addition, its innovative formulation enables the clinician to easily detect excess cement, even below the gingival margin, and simply remove it in one piece.

TempoCemID has a high bond strength, which is designed to prevent leakage, but still allows it to be removed easily when required. Peroxide, methyl methacrylate and eugenol free it flows and mixes easily for ideal handling and without sticking to instruments.

Perfect for long-lasting restorations, TempoCemID enables clinicians to see their aesthetic worries vanish before their eyes.

DMG Dental Products (UK) Ltd 01656 789401
info@dmg-dental.co.uk
www.dmg-dental.com

› PATIENT PLAN DIRECT

A SIMPLER AND AUTOMATED WAY TO SWITCH PLAN PROVIDER

Switching dental plan patients from one provider to another is about to become a whole lot simpler and automated.

New rules and an accreditation scheme for organisations processing third-party Direct Debits means that dental plan providers will soon have to use the 'Bulk Change' process if a practice wishes to switch its plan administration from one provider to another.

The Bulk Change process allows for Direct Debits to be transferred automatically "in the background" from one provider to another, witho ut patients having to sign a new Direct Debit instruction, making life simpler and more convenient for everyone involved. Patient Plan Direct is the first plan provider to obtain accreditation under the new rules.

Simon Reynolds, Commercial Director at Patient Plan Direct, comments: "We welcome these changes, which create a competitively fair market and affords practices the freedom of choice to decide which provider to work with, without being put off by a previously cumbersome switching process."

For more information visit:
www.patientplandirect.co.uk/simpleswitch

› NOBEL BIOCARE

NOBEL BIOCARE'S NEW TREASURE

Known for being a leader of innovation in implantology, Nobel Biocare has recently added a new string to its bow with the introduction of NobelPearl™ implants.

A soft tissue friendly implant solution, NobelPearl is a 100% metal-free, two piece ceramic implant with an internal cement-free locking mechanism that provides a unique alternative to titanium.

Geared towards esthetic excellence, these implants help to support the natural soft tissue appearance and are especially useful for cases where patients may have a thin gingival biotype.

Furthermore, as the implants are made from zirconia they have been designed to encourage excellent soft tissue attachment and minimize inflammatory response, encouraging predictable results.

Combine these benefits with a low plaque affinity and natural looking esthetics, and you can see why Nobel Biocare's new solution is a treasure well worth discovering.

For more information, contact Nobel Biocare on 0208 756 3300, or visit www.nobelbiocare.com/pearl

Tipton Training
EMPOWERING DENTISTS

British Academy of Restorative Dentistry

PG CERTIFICATE IN OPERATIVE DENTISTRY

From the UK's Leading training provider.

PROF PAUL TIPTON IS COMING TO SCOTLAND

"The Tipton Operative course has given me the skills and techniques to provide high quality private dentistry to my patients. Case acceptance is up and treatment is predictable. Everyone performing dentistry on a day to day basis should take this course!"
A Young, 2017

PG Certificate in Operative Dentistry (Phantom Head)

Duration:	10 Days (weekends) +2 days Free E-Learning
CPD:	60 hours
Date, Location and Price:	Lanarkshire, February 2019, £399+VAT per day

Jump start your career in 2019 with an investment in the best training on the market.

The renowned Tipton Training courses can now lead to BARD Certificates & Diplomas which transform your skills and cover Enhanced CPD requirements.

Course benefits include:

- ✔ Increase your Income
- ✔ Gain the skills to move into private work
- ✔ Learn the latest techniques and the tried and tested
- ✔ Gain Postgraduate qualificationsat the same time
- ✔ Learn in live dental environment
- ✔ Don't refer patients and incomeout of your practice
- ✔ Learn from Prof. Paul Tipton and his team.

Topics Covered.

- ✔ Bonded Crowns Preparations
- ✔ Veneers Preparations
- ✔ Composite Preparations
- ✔ Porcelain Inlays/Onlays
- ✔ Posts
- ✔ Amalgams
- ✔ Anterior and Posterior tooth preparation
- ✔ Bridge Preparations
- ✔ Gold Preparations
- ✔ Marylands

Option to Upgrade to Level 7 after completion.
RPL Policy Applies.

Available courses include
(Once Level 7 has been achieved)

- ✔ Restorative Course
- ✔ Aesthetic Course
- ✔ Prosthodontics Course
- ✔ Implant Course

BOOK NOW | AVAILABLE ON WEEKENDS | STARTING FEBRUARY 2019

Please note all courses include a preset £500 registration fee.

Tel: +44 (0)161 348 7849 enquiries@tiptontraining.co.uk www.tiptontraining.co.uk

What's your view on oral cancer?

GOCCLES®

PREVENTION AND EARLY SCREENING CAN SAVE LIVES

Oral cancer is one of the most frequent cancers globally, unfortunately its late stage detection is a common problem worldwide.

Early discovery is the most important step in reducing the death rate: when detected in first stage, patients have an 80 to 90 percent survival rate.

Knowing the risk factors and regular check-ups, including a screening of the entire mouth, are essential in the early detection of cancerous and precancerous lesions.

With the innovative Goccles you can run a simple, non-invasive and painless test of the oral cavity, for early screening of oral cancer and other precancerous lesions.

Learn more at: www.dentalsky.com/goccles-oral-cancer-screening-glasses

Dental Sky

Order online at **www.dentalsky.com**
or call FREE on **0800 294 4700**

Dental Sky Wholesaler Ltd Unit A, Foster Road, Ashford, Kent TN24 0SH Fax: 0800 294 4701 E-mail: sales@dentalsky.com

Photograph courtesy of Professor Mike Lewis - School of Dentistry, Cardiff University.

LuxaCrown: The easiest way to long-lasting crowns.

From now on, restoring is child's play: With the new LuxaCrown you can make long-lasting crowns easily, quickly and cost-efficiently – directly at the chairside. The easy to make composite crown fits precisely, is highly aesthetic and shows a remarkable longevity. A LuxaCrown restoration could last for up to 5 years.* With this unique semi-permanent solution, you can offer your patients longevity with excellent results as a cost-efficient alternative to lab processed crowns.

Discover the new possibilities for you and your patients. With LuxaCrown from DMG.
www.dmg-dental.com

DMG

*In vitro study of LuxaCrown; N. Albrecht, S. Duy, Germany, FEB 2016

پنل عملکرد

عملکردهای متنوت با دکمه برای تنظیمات دستی، کراشوار از جنس شیشه نشکن و دکمه On/Off چراغ که بر روی پنل در Side Table قرار داده شده است.

Rotating double-jointed table arm

تیبل آرم دو مفصله چرخشی

تیبل آرم چرخشی دو مفصله باعث استفاده بهتر از فضا برای دستیار پزشک و کاربردوستی می شود.

Water supply system with double sensor / Glass spittoon container

سیستم لیوان پر کن هوشمند/ محتوی اسپیتون شیشه ای

تغذیه آب وکراشوار از جنس شیشه نشکن طراحی شده با شکل و ارتفاع مناسب برای بیماران در تمامی سنین و افزایش آرامش و راحتی بیمار می باشد. علاوه بر آن سیستم لیوان پر کن هوشمند حجم آب مورد نیاز را کنترل می کند و شیشه ی شفاف و بزرگ کراشوار نظافت آن را دقیق تر و بهتر خواهد کرد.

With adjustable water supply / Switch for hot water

مخزن آب قابل تنظیم/ مجهز به سیستم آبگرمکن

دکمه کنترل ذخیره آب و زیر آب، On/Off برای آب داغ، تعبیه شده در قسمت جلوی یونیت که باعث راحتی کار کاربران می شود.

USB Port & 220V power socket

خروجی USB و سوکت ۲۲۰ ولت

Suction filter & side rack

فیلتر ساکشن و میز ابزار

فیلتر ساکشن با قابلیت شستشوی آسان نظافت و نگهداری را آسان می کند و میز ابزار قابل جدا شدن قابلیت نگهداری ابزار گوناگون در طول درمان را دارد.

www.azadmed.com
Tel: +98 21 88 98 80 63 - 6