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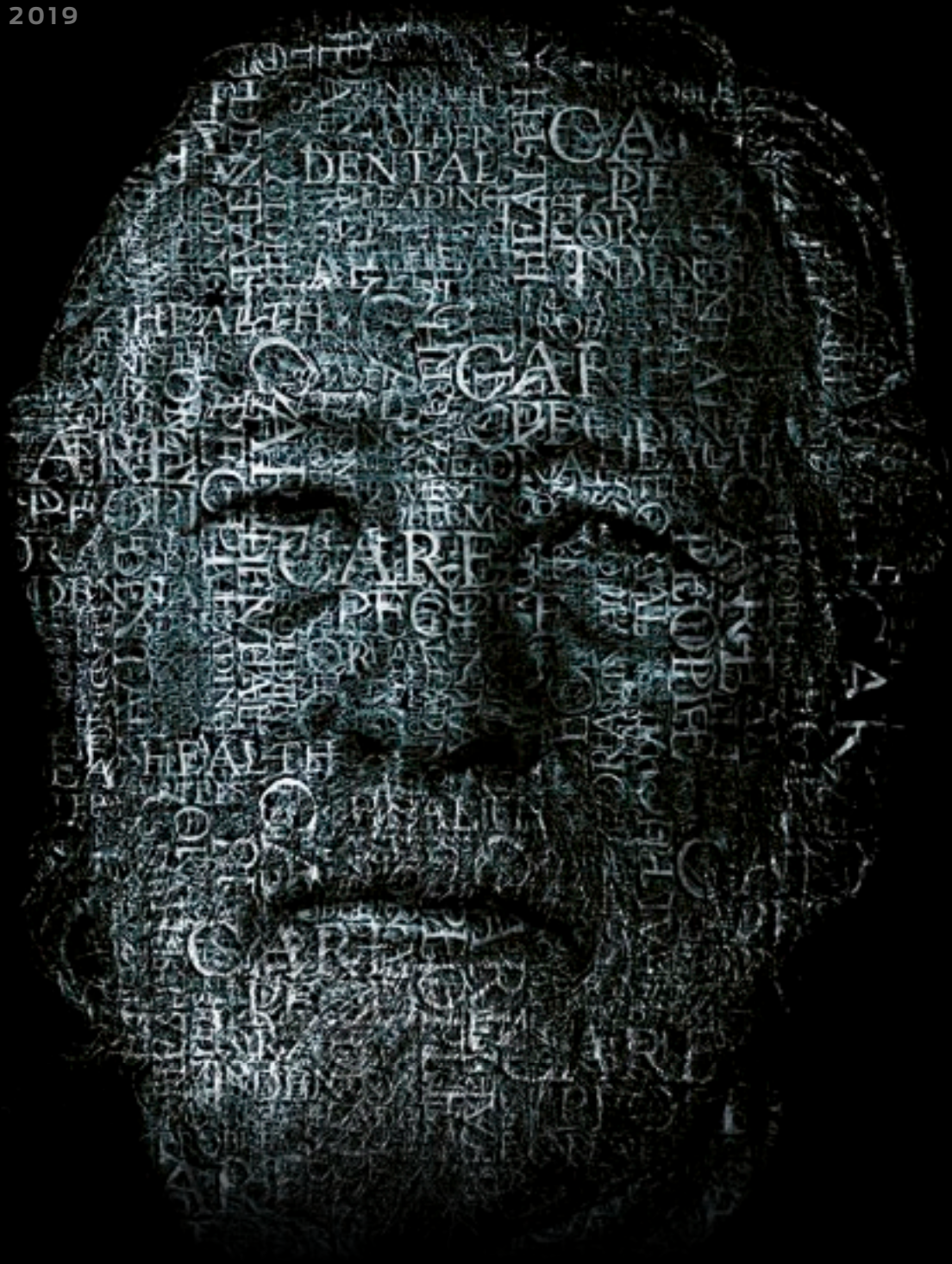
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# Scottish Dental

FEBRUARY 2019

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# THE AGEING FACE OF DENTISTRY



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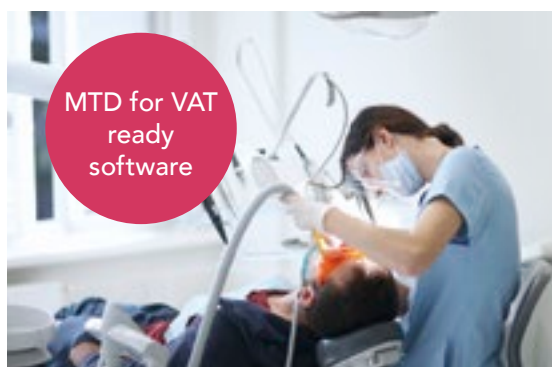
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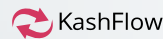
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# Bullying cultures allowed to fester

*Being told to toughen up is not enough. This scourge of society must be recognised and confronted*

Once upon a time bullying was a word confined to childhood. A term that conjured up images of the playground and telling yourself that 'sticks and stones may break my bones, but words will never hurt me'. Children who were bullied were told to ignore it, be tougher. It also used to be that the image of the brusque, aggressive authority figure was well known and accepted, especially within healthcare, think Sir Lancelot Spratt in the 'Doctor' movies. Their colleagues were meant to ignore it, be tougher. But the truth is that bullying has never been confined to the playground; the real Sir Lancelot Spratts weren't just pompous and bad-tempered, they were the accepted face of bullying in the workplace.

Today, as in the past, bullying and undermining behaviour permeates our society and, for those on the other end of it, turning the other cheek is easier said than done. The saving grace is that at least society is recognising this, shining a light on it, understanding the impact, and trying to do something about it. There is a large amount of evidence as to the prevalence and impact of bullying, undermining and harassment within healthcare, and there have been several high-profile campaigns encouraging healthcare professionals, representative groups and the NHS to work together to stamp out these damaging behaviours. Although these campaigns have touched nearly every profession within healthcare, and some have even had a token nod toward dentistry, as of yet, there has been nothing which grasps the nettle for dental professionals.

Are we to understand from this, therefore, that it isn't a problem in dentistry? Evidence and anecdote would suggest otherwise, and in this edition you can read about the issue and the work that is being done to define and address it.

But I want to talk about something else, I want to talk about what it is really like to be on the other end of a bully. Because of the lingering association with childhood and childishness, we still tend to trivialise bullying and the damage that bullies do, treating the victims as if they are somehow slightly pathetic, and perhaps just not tough enough to cut it. Even with so much more understanding of the issues, adults who are bullied can be reluctant to report it because there remains a sense that it is somehow

shameful, but there is nothing shameful or trivial about being a victim or about the consequences of bullying and undermining.

Imagine feeling constantly mentally and emotionally attacked in your workplace. Imagine taking that home with you every night, lying awake, replaying what happened and suffering acute anxiety about what may happen the next day. Imagine becoming so riven with self-doubt, constantly questioning whether you are good enough, whether you can still do your job, whether you should just give up. Imagine it becoming so bad you need medication to cope. Perhaps you don't need to imagine and have gone through some or all of this, because none of this is fictional.

Bullying is not trivial; it can wreak havoc on individuals, teams, and organisations. To have a team member suffering in this way can severely impact the team itself, rendering it ineffective with both the victim, and their colleagues who witness the bullying and undermining, afraid to speak up, afraid to tackle the bully. Imagine if that bully makes a mistake which could harm a patient, but the team around them is too scared to speak up and stop it.

Too often within the institutions and organisations associated with healthcare, bullying cultures have been allowed to fester. Bullies have been downplayed as being assertive or demanding and have escaped any consequences for their actions. To truly tackle it we must admit that it is there and this, at least, is now happening.

With widening acknowledgement, however, has come a more recent trend to teach resilience, both at school and in the workplace as a way to deal with bullying. From primary school, children are widely taught about how to be more resilient, and resilience training is routinely offered to adults who have faced, or are facing, difficulties at work. Resilience is an important tool for helping people to cope, but we have to be careful that it doesn't become a way of making bullying the victim's problem. Effectively, by saying, 'be resilient', we are once again telling victims of bullying to toughen up and ignore it. This may help the victims deal better with the situation, but it doesn't challenge the bullying behaviour, nor does it change the culture which allows bullying and undermining to flourish.

To really change things we have to first acknowledge the problem and then say boldly that it is not OK, we will not accept it, and we will not give bullying and undermining a home, anywhere.





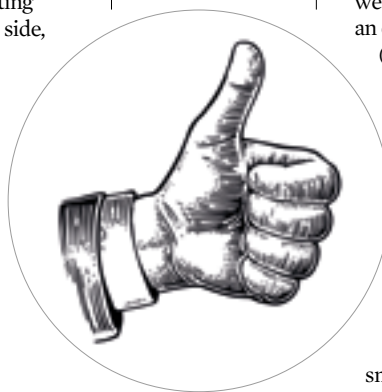
## It's positively time to be more respectful of our profession

*Feeling unappreciated and undervalued? Well, it's time to stop fixating on a small number of negative outcomes, celebrate our success and demonstrate our worth within the NHS and wider community*

**A** new year, a new me. Isn't that the way it goes? Well thus far, as Arthur, I've been erring a little on the negative side. I've decided, in the spirit of the new, to go for a positive spin. I was talking to some dentists recently; it's something I do from time to time although I try to keep that limited. (Note to self: stay positive). In conversation, and ignoring the usual gripes and moans, someone pointed out that we do OK. He was right. I think, fundamentally, dentistry is a good job. We do something quite remarkable and worthwhile. How many other people get to say that?

What does concern me is that, in line with almost the entire NHS, we are undervalued. Actually, I think that's inaccurate. Like all the health service, we only hear stories about the terrible; mistakes, law suits, appalling waiting times, poor staffing and budget cuts. On the positive side, there are stories about world-beating advances, the spectacularly rare or long-shot positive results. This does not reflect the overwhelming number of procedures and interactions which simply go as they are supposed to. So what we are (the NHS) is misunderstood and therefore unappreciated for the enormously successful and varied work that is done in the name of healthcare. Not to mention free at point of delivery.

In dentistry, the vast majority of procedures are carried out satisfactorily with very low costs (compared to other western countries). The value for money for patients and the NHS is remarkable. From a technical point of view, the 'average' dentist has to be able to perform a staggering array of treatments to, nowadays according to the GDC, consultant/specialist level. (Keeping it positive.) And for the most part, we do. Patients can experience virtually all they need in dentistry in a high street dental practice. I don't know the figures, but I'm pretty sure the vast majority of patients never have to be referred for specialist services. In this age of specialism, this may change, but for the foreseeable future this is likely to continue. This is a good thing for patients; they don't have to go elsewhere or be inconvenienced and we get to have a wide and varied professional life with a variety of skills and processes.



On the people front, again, the vast majority of patients are pleasant and respectful of the job we do and the people we are. In working with the public, you have to take the rough with the smooth and I'm quite sure we get a better run than your average supermarket worker. I know the reception staff tend to get the brunt of complaints and abuse and when patients come into the surgery they are nice as ninepence. Surely that's a positive too?

Kudos? Well, I think we often feel like the poor cousin in the medical world. I'm not trying to squeeze a pressure point. We do get some respect from our medical colleagues. It might be about our quality of life or the financial benefits we have. However, we didn't have to undergo years of beasting by consultants, endless 70-hour weeks involving night shifts and being surrounded by sick people. Not to mention the actual life and death responsibility. (A polite note to our specialist dental/surgical colleagues: you probably had to endure all of this, sorry.)

Now financially, we do all right, don't we? Let's not be coy. We have to work pretty hard for our money and it certainly seems to be getting tougher in the public sector. I suspect it's still a bit tight in the private sector too as dentistry probably exists at a pretty low echelon in the public consciousness when it comes to fiscal priorities. We can afford nice houses, cars, holidays and why shouldn't we? We are highly trained, multi-skilled professionals with an extraordinary capacity for persuading our fellow man (and woman) to go through some scary and unpleasant procedures for their medical benefit and all of this for a pretty much 9-5 job.

So to sum up, we do a very difficult but extremely worthwhile job. Caring for people, we build long-term relationships with patients in ways other healthcare providers never experience. We are skilled and respected professionals with the opportunity to own healthcare businesses. We get paid pretty well for a 9-5 job. What we don't tend to do is tell people this. We don't remind one another. We have a horrible tendency to fixate on the small number of poor outcomes or interactions that don't go well. As a profession, I think we should be more respectful of our position. We are, dare I say it, pretty lucky. However, much more importantly, we should find a way to communicate the value of the massively successful work we do. Demonstrate our worth within the NHS and wider community. Show our patients, the ones we have the long-standing relationships with, how we produce high-quality care. How we adhere to guidelines for ongoing management, treatment and premises with an exceptionally low profit margin. The trick is to do this without sounding trite or condescending. I think the way to do this is with a positive approach to our own profession.



# Brexit exit of dentists

*GDC research finds that eight in 10 of EEA-qualified dental professionals in UK are intending to leave because of uncertainty*

**ALMOST** a third of EEA-qualified dental professionals working in the UK are considering leaving the UK in the next few years, and of those intending to leave, more than eight in 10 said that Brexit and the uncertainty about arrangements for EU citizens living and working in the UK was a significant factor in their reasoning. However, more than half of those considering leaving said this might change if their EEA qualifications continue to be recognised in the UK.

These are the findings of new independent research commissioned by the General Dental Council (GDC) to help understand the potential impact of Brexit on the UK registers of dental professionals. Almost one in five UK dentists, and about the same proportion of new applicants to the professional register each year, have qualified in the EEA.

The large majority of respondents, 84 per cent, agreed that Brexit is leading to a shortage of healthcare workers in the UK, while 75 per cent agreed that it is leading to a shortage of dental professionals. On the back on the GDC survey, the

British Dental Association has expressed deep concerns that the government has thus far been unwilling to engage on growing recruitment and retention problems.

Last year, BDA surveys indicated that more than two-thirds (68 per cent) of NHS practices in England who attempted to recruit in the last year struggled to fill vacancies. Half (50 per cent) of the NHS practices which attempted recruitment had reported issues in the previous year.

The BDA says that recent official data has shown morale among dentists has hit an all-time low, with lower levels of morale also linked to higher NHS commitments.

BDA chair Mick Armstrong (pictured) said: "Government has failed to even acknowledge the scale of the crisis that's been facing dentistry for several years. Broken NHS contracts, rock-bottom morale and now Brexit are all taking their toll.

"The writing is now on the wall for too many European and UK-qualified dentists. Government needs to wake up, and smell the coffee. NHS dentistry can't be run without dentists."

However, the

GDC said it has seen no evidence of EEA-qualified dental professionals leaving the UK registers since the 2016 referendum, and said this trend continued in the December 2018 dentists' annual renewal.

David Teeman, GDC's head of regulatory Intelligence, said: "Exploring the intentions of people who are currently able to work in UK healthcare because their qualifications are recognised under EU legislation is essential.

"This research was undertaken before important issues have been resolved, such as recognition of qualifications, residency rights and access to the UK for existing and prospective dental professionals. Once these issues are settled, we are planning a further round of research, which will aim to provide us with increased insight and aid us in our planning. We recognise the information could be useful to others; for example, those involved in workforce planning, and will therefore be making it publicly available also."

*For a copy of the full report, visit the 'General regulation' section of the GDC's research page online*





# Action demanded to stamp out bullying in health service

**AFTER** last year's spate of bullying allegations by whistleblowers at a number of NHS Trusts, including Lothian, Tayside and Highlands, the British Medical Association (BMA) has called for urgent action to stamp out bullying and harassment in the health service.

In his New Year message, BMA Scotland council chair Lewis Morrison said it was a "scandal" that a culture of bullying and harassment should be allowed to thrive in the NHS, and warned of its repercussions for patient care.

This concern was backed up by a BMA survey of members revealed that almost four in 10 (38 per cent) say that bullying and harassment is an issue in their workplaces. Although there are no comparable studies into bullying in Scotland's dental sector, the issue is highlighted in a number of NHS-related surveys, which include feedback from NHS dentists.

For example, in the latest NHS England staff survey, which includes feedback

from both doctors and dentists for 2017, 24 per cent reported incidents of bullying, harassment and abuse by managers and other staff, while 28 per cent reported this behaviour from patients and relatives.

Of the 30,000 doctors and dentists who responded to the NHS England staff survey in 2016, 24 per cent reported that they experienced some form of bullying or harassment in the preceding year: 13 per cent of doctors and dentists said they had been bullied or harassed by their manager, while 16 per cent said they had been bullied or harassed by another colleague. According



**THE LEVEL OF BULLYING IN SCOTLAND'S NHS CAN ONLY HAVE SERIOUS CONSEQUENCES"**

to this survey, only a minority of doctors and dentists who experienced bullying or harassment reported it to their employers.

Dr Morrison said BMA Scotland would launch a major initiative in 2019 to understand people's experience of this unacceptable behaviour, to probe causes, and find solutions and he called on the Scottish Government and NHS managers to work together to make Scotland's NHS a more positive place to work, including a summit planned for early summer.

He added: "In any workplace, these levels of bullying would be extremely worrying. In the health service, where what we do can make the difference between life and death, it is nothing less than a scandal.

"Ultimately, the level of bullying and harassment we currently see in Scotland's NHS can only have serious negative repercussions for the care it provides."

*A bullying culture – Page 36*

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# Attendance gap is continuing to grow

*Patient registration at record level but fewer adults from poorer areas are visiting their dentists regularly*

**PEOPLE** from Scotland's most deprived communities are attending the dentist less often than their more affluent peers, according to figures recently released by NHS Scotland's Information Services Division.

Although overall registration in Scotland is at record levels (94.2 per cent), data shows that the attendance gaps for adults and children have trebled in the past 10 years.

Among adults, 62.2 per cent of those in the poorest areas had visited their dentist in the last two years, compared to 72.7 per cent of those in the most affluent neighbourhoods. Among children, the figures were 79.8 per cent and 89.2 per cent respectively.

The attendance gaps of 10 percentage points for adults and nine points for children have both gone up from just three percentage points in 2008.

Notably, adults on lower incomes are more likely to be registered with an NHS dentist than their wealthier counterparts, at 97.5 per cent compared to 88.6 per cent.

The figures have resulted in calls for the Scottish Government to do more to

increase attendance by adults in deprived areas.

Robert Donald, chair of the BDA's Scottish Council, said: "Year on year, the Scottish Government has attempted to hide behind positive-sounding registration numbers. But these figures are based on 'lifetime registration', and nothing can conceal the gap that's now opened between rich and poor when it comes to attendance.

"The people missing out on appointments are precisely those we most need to see.

"Residents in Scotland's most deprived communities are more than twice as likely to develop and die from oral cancer, and early detection is key."



**94.2%** of the Scottish population is registered with an NHS dentist

**5.1 million**

people were registered with an NHS dentist as at 30 September 2018 (94.2% of the Scottish population). An increase of 1.7 percentage points since last year

**97.5%** of adults living in the most deprived areas were registered with an NHS dentist compared to 88.6% in the least deprived areas



**NOTHING CAN CONCEAL THE GAP THAT HAS NOW OPENED UP BETWEEN RICH AND POOR WHEN IT COMES TO ATTENDANCE**

**ROBERT DONALD**

## Study finds potential gum disease link to Alzheimer's

**GUM** disease has been linked to Alzheimer's in new research findings published in the journal *Science Advances*.\*

The publication highlights a study which suggests that *P. gingivalis*, one of the main pathogens involved in tooth loss, may also play a role in developing Alzheimer's.

The study was sponsored by the biotech start-up Cortexyme Inc. of South San Francisco, California. Co-founder Stephen Dominy is a psychiatrist who in the 1990s

became intrigued by the idea that Alzheimer's could have an infectious cause.

There is as yet no agreement that *P. gingivalis* is behind the disorder, though its important role has been acknowledged. Neurobiologist Robert Moir of Massachusetts General Hospital told the journal *Science*: "I'm fully on board with the idea that this microbe could be a contributing factor. I'm much less convinced that [it] causes Alzheimer's disease."

The last comprehensive dental

survey of adults found that gum disease affects 45 per cent of the population. The condition varies from mild inflammation to reddened, swollen or bleeding gums and, at the advanced stage, loose teeth.

Other studies have found links between poor oral health and conditions such as heart disease and diabetes.

BDA scientific adviser Professor Damien Walmsley said: "This study offers a welcome reminder that oral health can't remain an

optional extra in our health service. Everyone's life can be improved by regular appointments and good oral hygiene, reducing the bacterial load that's ever present in our mouths to a level that's unlikely to cause tooth decay, gum disease or tooth loss."

\*Source: <http://advances.sciencemag.org/content/5/1/eaau3333>

Help the ageing – page 20



NEWS  
IN BRIEF

## International preventative care survey

An international research project is asking primary care dentists in the UK, Ireland, Denmark, Germany, and the Netherlands to answer two short questionnaires, which have been developed as part of the EU-funded Added Value for Oral Healthcare (ADVOCATE) project that aims to encourage a preventative approach in dentistry.

The Faculty of General Dental Practice (FGDP(UK)) is one organisation supporting the research by encouraging dentists to give a few minutes of their

time to participate.

There are two surveys; the attitudes questionnaire aims to capture dentists' beliefs and experiences around delivering preventative care to adult patients; and the preferences questionnaire asks dentists to consider clinical scenarios in which photographs and radiographs of patients of a given age and caries risk level are presented.

The surveys can be found online through the FGDP website and will close around the beginning of March. They do not request any personal data.

## Gum disease and pregnancy

A study published in the *Journal of Clinical Periodontology* has found that pregnant women with gum disease are significantly more likely to go into early labour, according to the findings of a new

study. Research discovered that women who entered labour early were one and a half times more likely (45 per cent) to have gum disease than women who experienced a perfect pregnancy (29 per cent). The study also found that early birth rates were more common for women with untreated tooth decay or fillings.

## CPD review published

The GDC have published the results of their commissioned literature review of continued professional development (CPD) activities, models and best practice. The review was carried out by the Association of Dental Education in Europe (ADEE) from June to October 2018. Researchers reviewed more than 800 publications on CPD, from across the UK and internationally, and surveyed research areas experts,

including those from health regulators, and beyond. The GDC will now use the findings of the review to drive future development of CPD for dental professionals. The full findings of the review, and an executive summary, can be found on the GDC's website.

## SDCEP app updated

The SDCEP 'Dental Prescribing' app has been updated following amendments to the latest edition of the British National Formulary (BNF 76) which was published in September 2018. This update includes information on the 2016 amendment to NICE Clinical Guideline 64 'Prophylaxis against infective endocarditis' and the associated SDCEP Implementation Advice which was published in August 2018.



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## DATES FOR YOUR DIARY

### 20 FEBRUARY

**BDA Scotland, East of Scotland Branch: Preventing violence – do dentists have a role? Lessons from 10 years of Medics against Violence**

With Christine Goodall  
Royal Scots Club, Abercromby Place, Edinburgh EH3 6QE\*

### 22 FEBRUARY

**BDA Seminar – Compromised teeth and failing restorations**

Safe and sensible approaches to the management of clinical failures for the dental practitioner  
BDA, London\*

### 22 FEBRUARY

**Reception and telephone skills for the whole dental team**  
London - BDA\*

### 27 FEBRUARY

**BDA Scotland, West of Scotland Branch – An evening with David Cross on auto-transplantation**  
Royal College of Physicians and Surgeons Glasgow (RCPSG) – Glasgow\*

### 28 FEBRUARY

**Informed Consent: Sharing the Decision (ICONS) (Birmingham)**  
Royal College of Surgeons Edinburgh (RCSEd)\*\*; Birmingham

### 28 FEBRUARY

**BDA Scotland, Aberdeen Section – Complete and partial dentures**  
With Kevin Lochhead  
Doubletree by Hilton Hotel, Beach Boulevard, Aberdeen AB24 5EF

### 2 MARCH

**23rd Annual Conference for Dental Care Professionals**  
RCSEd\*\*

### 12 MARCH

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[www.ids-cologne2019.org](http://www.ids-cologne2019.org)

### 14-15 MARCH

**25th World Congress on Dentistry and Oral Health**  
Park Inn by Radisson Hotel and Conference Centre, London Heathrow  
<https://dentistrycongress.dentistryconferences.com>

### 15 MARCH

**The Academy of Clinical Educators (ACE) Conference: PULSE 2019**  
RCPSG, Glasgow\*\*\*

### 18 MARCH

**An update on SDCEP Guidance**  
RCPSG, Glasgow\*\*\*

### 27 MARCH

**BDA Scotland, West of Scotland Branch – Dental implants: the ultimate solution?**  
With Iain Chapple  
RCPSG, Glasgow\*

### 26-27 APRIL

**Scottish Dental Show**  
Braehead Arena, Glasgow G51 4BN  
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### 26 APRIL

**Training essentials – Management of medical emergencies in the dental practice**  
BDA, London\*

\*More information for BDA events at: [www.bda.org/events](http://www.bda.org/events)

\*\*More information for RCSEd events at: [www.rcsed.ac.uk/events-courses](http://www.rcsed.ac.uk/events-courses)

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

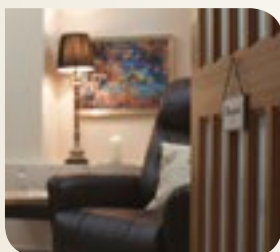


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Glas Specialist in Endodontics,  
GDC No. 62862

Dr. Carol Tait graduated with honours from Dundee University in 1987 and completed her specialist training at University of Dundee in 2004. Carol has been

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#### Dr. Robert Philpott

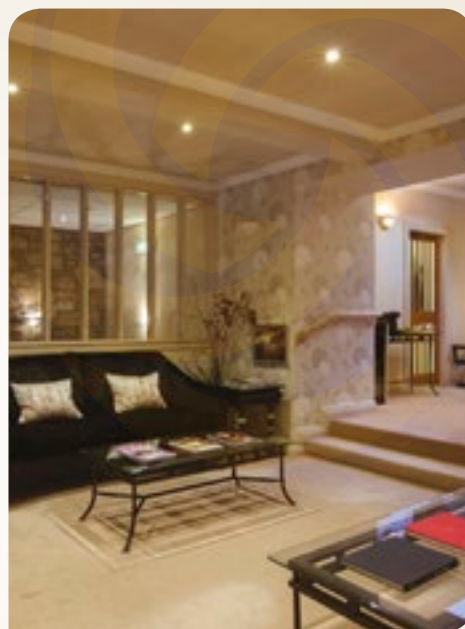
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Bob qualified from University College Cork Dental School in 2003 and completed his three year specialist endodontic training at the Eastman Dental Hospital in London in 2009,

graduating with distinction. He has worked as a specialist in endodontics in Ireland, England and Australia. Bob provides specialist endodontic services at EDS.

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# Help the ageing

WORDS  
STEWART MCROBERT

*With more people living longer, the healthcare system is coming under increasing pressure, especially the dental services available to those living in care homes*



**S**cotland's ageing population is presenting new challenges to our healthcare system. One of the most pressing is the lack of dental services made available to residents of care homes.

The Scottish Government has recognised the seriousness of the situation – the recently published Oral Health Improvement Plan (OHIP) has a section entitled 'Meeting the Needs of an Ageing Population.' However, there are demands to make sure that efforts are neither piecemeal, patchy nor lacking in proper funding.

Peter Ommer, Clinical Director (Dental), NHS Ayrshire and Arran, said: "To understand the current situation you have to look back at the past. Previously, care homes had residents mostly in their 60s, 70s and 80s who had no teeth and relied on dentures. That made the provision of dental care quite straightforward

"However, now homes are full of people who are living into their 80s, 90s and beyond, taking a plethora of medications, have more of their own teeth and have undergone a variety of procedures such as root treatment and having implants fitted. That makes the picture far more complex."

He pointed out that the medication older people take can often affect their bones, saliva and other functions making teeth far more prone to decay and complicating treatment. Food is often 'spiced up' with sugar to compensate for failing taste receptors and there can be difficulties with poor nutrition. Care homes can be subject to high staff turnover and often homes find it difficult to provide continuous staff training.

Compounding the issue is the possibility – even likelihood – that the older person involved is living with dementia. It all makes for a very difficult situation with a multitude of barriers that may discourage many GDPs from getting involved.

Equally daunting can be the paperwork involved. The GDC requires that every patient must have a written treatment plan that they must give informed consent to. If, however, you are dealing with a person classed as lacking capacity, it is essential to observe the relevant legislation and involve other parties such as a Welfare Power of Attorney if one exists.

This can result in a long-drawn-out process, especially if there are no living family members or the only remaining relative lives abroad.

Similarly, providing operative dentistry in a care home setting is fraught with difficulty – there is a limit to what can be done safely. Even assessing someone in their own surroundings then bringing them to the surgery for treatment can present challenges. They may use a wheelchair or Zimmer or are so frail that they need ambulance transport.

However, such transport in Scotland will not deliver

## Adults with incapacity

Many older people in care homes may have an Adult with Incapacity (AWI) certificate in place for areas of health and social care, which can make delivering treatment a minefield that must be navigated with proper legal authority.

The Adult with Incapacity Scotland Act and the Adult Support and Protection Act (2007) protects anyone over 16 who is classed as lacking capacity. A Welfare Power of Attorney or Welfare Guardian must be in place to look after that person's health interests and rights.

Dr Petrina Sweeney of Glasgow Dental Hospital said: "If neither is in place, any treatment must be authorised by the person's nearest relative/carer. If there are no living

relatives things become even more complicated, and you may have to involve professionals such as a hospital consultant or general practitioner."

Dental treatment requires a specific time-bound AWI certificate. It may last six months, during which time you can carry out a full treatment plan if required. After six months it has to be re-written. The maximum period is three years, but that would only allow general oral care. Any other specific course of treatment would require a separate authority covering the time that treatment takes.

What's more, you would need a separate certificate to administer a general anaesthetic.



**MOST GDPs DON'T ENTER CARE HOMES, ARGUABLY BECAUSE IT'S AN ENVIRONMENT THAT'S OUTSIDE THEIR COMFORT ZONE"**

to a high street dental practice, only to a hospital or, on very rare occasions, a health centre. What's more, your patient could find they are one of many passengers and spend long hours travelling while others are picked up and dropped off.

### **Domiciliary care**

Although most GDPs don't receive training in this field once they've left dental school, regulations say that any dentist can work in a care home. Of those that do, some are keen to provide ongoing care to existing patients, others simply want to help care homes and their residents. Peter said: "However, most GDPs don't enter care homes, arguably because it's an environment that's outside their comfort zone and one where there is the risk of being faced with medically or behaviourally complex cases."





→ In an attempt to start tackling these issues, the OHIP spells out new domiciliary care provision. Specifically, the Scottish Government intends “to develop an accreditation scheme for GDPs with the necessary skills and equipment to see patients in care homes. These practitioners and their teams would work with care home staff to ensure adequate preventive care is in place for residents, complementing the PDS, which will continue to provide those procedures that cannot readily be done by a GDP. With the increasing numbers of people living in care homes, it will be necessary to ensure the PDS are only used for patients requiring their advanced skills as in a shared care model”.

Plans are under way for an eight-day training programme for GDPs. This will involve two 20-strong cohorts with sessions taking place in March and April 2019 in Edinburgh and Glasgow. They will cover areas such as Adult With Incapacity (AWI) certification, and participants will gain greater understanding of the complex medical situations that can arise.

Health boards are currently recruiting interested GDPs, most likely individuals who are already working in care homes. Once they have undertaken the training they will work with the PDS in a buddy system to gain a full picture of the care home system.

Peter welcomed this move: “We want to encourage co-operation between GDPs and the PDS.”

Efforts to register every care home with a GDP have already taken place, with one scheme under way in Greater Glasgow and Clyde Health Board area. “It has been largely successful,” said Dr Petrina Sweeney, Clinical Senior Lecturer/Honorary Consultant at Glasgow Dental Hospital and School.

“It has taken a couple of years and it benefited from being in line with the thinking of the former Chief Dental Officer. However, across Scotland there’s a patchwork approach and other health boards have done things differently. Hopefully, the aims set out in the OHIP will bring consistency.”

Petrina recognised the lessons that can be learned and emphasised how working in this area often requires a change of mindset for GDPs: “It’s vital they can recognise what ‘normal’ looks like in an older mouth. Medication can have knock-on effects; for example, the mucosa can look and react differently than before. Naturally, a GDP will want to create a ‘perfect’ mouth condition, but the

Peter Ommer,  
Clinical Director  
(Dental), NHS  
Ayrshire and Arran



Scotland's pensionable age population is projected to increase by

**25%**

from 2016 to 2041



In 2017  
19% of people  
in Scotland  
were aged

**65+**

In the same  
year people  
aged under  
16 made up  
17 per cent of  
the population



**57%**

The increase in  
the number of  
centenarians  
between 2006  
and 2016

Source: National Records of Scotland

reality is that the person they are treating might have a few months to live; is it the dentist's job to create a perfect smile or to make that person comfortable?

“We appreciate that people feel wary about being accused of neglect but in many cases lots of intricate work cannot be justified. With older mouths it's most important to make sure they are functional, reasonably clean, and not sore. That improves the patient's quality of life – they can eat, are comfortable and somebody can keep their teeth and mouth clean.”

Given her role, Petrina is acutely aware that it's not just the population that's changing, dentists are too. “Because society in general has become more litigious, younger dentists are more aware of potential risks. At the same time, compared with previous generations, they receive training that covers a very wide spectrum.

“Special care dentistry itself became a specialty in 2008 and at Glasgow Dental Hospital we deliver a full curriculum. We start in BDS2 right through to BDS5. Students get taught about all aspects of special-care dentistry, and a big part of that is dentistry for older people.”

### Caring for Smiles

It's hoped that the ambitions outlined in the OHIP will build on initiatives such as the Scottish Government's Caring for Smiles project, which promotes oral hygiene in care homes. The campaign has been rolled out across the country. However, it faces several issues, not least the high turnover of care home staff, which undermines efforts to establish ongoing care.

Petrina said: “Since 1980 I've worked with lots of excellent people to improve oral care in care homes, for older people and other vulnerable groups. Campaigns work as long as you provide support. The minute you stop and the staff/management change everything falls



apart. It's not fair to blame carers. They have competing priorities, not simply looking after someone's teeth, but all aspects of their welfare.

"The truth is that often there are too few staff, they don't get paid enough or trained enough. There needs to be a change in ethos and people need to understand how the mouth provides an insight into the body's overall health."

Nevertheless, with Caring for Smiles working with well-established GDPs and the PDS, oral hygiene will improve, leading to better health and saving money. Peter said: "A major cause of death in care homes is pneumonia, and one of its main causes is lack of oral hygiene. We can reduce the need to protect someone with antibiotics simply by brushing their teeth. It is well recognised that improved oral hygiene for all patient populations would save millions of pounds in hospitalisation and avoid more complex treatment."

No doubt the Scottish Government will hope that Caring for Smiles will have the same widely acknowledged positive impact as Childsmile, the campaign designed to reduce oral health inequality and improve access to dental services for Scotland's children.

However, matching that success could prove difficult. Petrina said: "Childsmile has been very well funded and prescriptive – everyone across the country has followed the same approach. The results have been phenomenal.

"However, Caring for Smiles does not have the same financial backing and health boards, while recognising the principles underpinning the campaign, sometimes struggle to implement it in a uniform manner. The idea of Caring for Smiles is great, but you have to put money into these things to make sure they are successful."

Despite these reservations, there is some evidence of success. Peter highlighted an example in Ayrshire where all care homes are signed up to Caring for Smiles, and a



**CARING SMILES DOES NOT HAVE THE SAME FINANCIAL BACKING [AS CHILDSMILE]. THE IDEA OF CARING SMILES IS GREAT, BUT YOU HAVE TO PUT MONEY INTO THESE THINGS TO MAKE SURE THEY ARE SUCCESSFUL"**

stripped-down version was introduced in the intensive care unit in Crosshouse Hospital. "Healthcare staff had been cleaning mouths using a sponge and mouthwash. We gave them some better options and dramatically reduced both the number of antibiotic treatments and cases of aspiration pneumonia."

#### **Cash is king**

Both Peter and Petrina are well aware that the goal of attracting more GDPs to work with care homes will depend to a great extent on cold, hard cash. They know GDPs are business people as well as highly skilled professionals being asked to do something different by tailoring treatment to people's quality of life. And they know dentists must be adequately compensated.

Peter noted: "As health boards, and as a country, we







are saying to GDPs ‘We will help you develop your skills, and the Scottish Government is looking at the financial package to recognise the accredited dentist who can take on this type of work.’ This shows the Scottish Government is willing to invest more in front-line care and it will pay dividends when we have fewer referrals to treatment in secondary care, which is significantly more expensive and more burdensome for the patient.”

While finance is fundamental, communication is the secret to success when it comes to smoothing out the steps of the process. “Everyone involved should be clear when a patient is at the stage where she/he should be being treated by a GDP or the PDS. The PDS should be the shoulder between primary and secondary care, delivering both, and supporting the GDP, as and when necessary.”

“GDPs simply don’t have the time to go through a convoluted process trying to make contact with, for example, a cardiology or haematology consultant. In those cases, a strong relationship with the PDS can come into play. PDS dentists are often familiar with the processes – they know the right people to contact and how to contact them.

“If you have an integrated system where each care home has an accredited GDP as well as the PDS dentist, then patients can travel along different stages of care in a seamless way.”

### Specialist concern

There remains widely expressed concern about the level of specialists in special care dentistry in Scotland. As patient conditions become increasingly complex more



## WE ARE WASTING THE TALENTS OF DEDICATED, SKILLED AND INTELLIGENT YOUNG PEOPLE WHO ARE KEEN TO SPECIALISE IN THIS AREA”

There is concern about the levels of special care dentistry available to support the needs of care home residents

specialists are needed. However, Scotland currently has the grand total of one specialist in training.

The specialty came into being in 2008 when a small cohort of self-trained experts were recruited to pass on their skills to the next generation. However, many of those are nearing the end of their working life. As a result the number of specialists on the register in Scotland will reduce by 50 per cent in 2025 compared to 2015.

Petrina said: “We currently have four consultants in special care dentistry, one of whom is about to retire. I am also nearing retirement at which point there will be two consultants for the whole of Scotland. We are not a big country, but we need more trained specialists in this field.”

As always, finance is the overriding issue. At the moment there are no funded specialist posts available. In turn that lack of opportunity discourages training





organisations; National Health Service Education for Scotland (NES) is understandably reluctant to invest in training specialists who end up working as non-specialist dental officers. "It's sad, because we are wasting the talents of some incredibly dedicated, skilled and intelligent young people who are keen to specialise in this area," said Petrina.

According to Peter there is no need to have a special care consultant backed up by a team of specialists in every health board area. "Each board is different – compare NHS Greater Glasgow and Clyde with NHS Orkney – so they might not all merit a specialist." Instead, he believes there are sound arguments for a regional model with every health board having access to some element of specialist support. The aim is to have services delivered as close to home as possible and avoid a situation where patients must travel a very long way for a brief consultant appointment.

He insists dentistry is ideally suited to regionalisation. "We need to work much smarter. Cases, where a frail patient needs the use of a hoist, for example, can be carried out locally, while specialist or consultant input can be advised remotely through the employment of technology, for example using video conferencing and an intra-oral camera to show the mouth, and with X-ray or blood results relayed electronically."

Both say that the new domiciliary care provision can be a start. If a significant number of GDPs are prepared to lend their expertise in care homes that pattern will become normalised, and the advantages – for patients, families, care homes, professionals, the healthcare system



Dr Petrina Sweeney, Clinical Senior Lecturer/Honorary Consultant at Glasgow Dental Hospital and School

and the country as a whole – will start to flow.

"The OHIP has useful ideas on preventive care, but integration of services is essential," said Petrina. "Unfortunately, we are trying to do things on a shoestring. If we could do the same 'spend to save' approach with Caring for Smiles that we did with Childsmile we would make substantial savings in the long run."

She highlighted the approach in palliative care and the end-of-life setting where, she said, oral care is treated with respect. "We have done a

lot of work with hospices over the last 20 years, and they have been methodical and careful to establish an evidence base for everything they do. As a result, the oral health care in hospices is of a very high standard."

Peter added: "The fact that people are living longer and are living with more of their own teeth is a credit to the NHS. What we have to do from a dental point of view is catch up with the delivery of the care that this positive result requires. In truth, this is a learning process that we are still going through."

"I believe today's GDPs have expanded their knowledge and expertise in different areas of dentistry. We need to keep evolving our approach in this area rather than assume we have it right. The OHIP opens the door but it's how we proceed – and how things are funded – that will make the difference."

## A project to test simple interventions

The topic of dental services for care homes is not unique to Scotland; it is a subject that needs to be tackled across the UK.

A research project involving Queen's University Belfast is being undertaken to identify the efficacy of a series of simple interventions that it is hoped will have a meaningful impact for care home residents.

Dr Gerry McKenna (pictured) of Queen's is one of those involved. He said: "This is a collaborative project. It is funded by the National Institute for Health Research (NIHR) and we are working with colleagues in the University of Bangor in Wales, as well as University College London, the University of Newcastle and the University of Glasgow."

"We are all aware that there is an increasing issue around the oral health of older people in nursing homes. It's fair to say that their oral health has changed

dramatically over the last 20 or 30 years.

"I'm also aware that there needs to be a very strong package of education for care home staff. There tends to be very high staff turnover in some places so anything we put in place must be long lasting."

Part of the impetus for the project are recent NICE guidelines (NG48 Oral health for adults in care homes) and the starting point will be to implement a number of interventions in 12 care homes in Northern Ireland, with another 12 homes in London subsequently taking part.

"We are currently going through ethical approval and will look to recruit care homes from May 2019 onwards. The project will run for 12 to 14 months."

According to Gerry,

there are huge variations in practice across the UK. "In some places the community dental service is very active in looking after residents and in other places private GDPs look after patients – it's very much on a home by home basis. This piecemeal approach has given rise to some of the issues we want to address."

"We are putting the emphasis on prevention and simple measures from the outset and hopefully getting away from big interventions further down the line, with teeth having to be taken out under general anaesthetic."

It is recognised that residents may have a multitude of conditions and require a huge amount of help from staff, but it is hoped the project will help emphasise that oral health must be a priority, otherwise the consequences are serious. "There are lots of

other things care staff have to consider but oral health is overlooked and it should be brought higher up the agenda," said Gerry.

Looking close to home, he said there is no policy similar to Scotland's OHIP in Northern Ireland, though it's an issue that needs to be addressed. "It may be that this piece of work we are doing over the next couple of years can contribute. I know that it is something the BDA in Northern Ireland is very keen to take forward."

"As someone who is very much involved in this area, I would like to see greater emphasis on how we care for older patients, not just those in nursing homes but pragmatic treatment planning for older patients in dental practices."

**For more information on the project see:**  
<https://bit.ly/2S9kUQy>



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# *Politics and* the dentist



*In the first of a series of interviews with individuals in key political and strategic positions, looking at the place of dentistry in politics, policy-making and the wider healthcare landscape, Sarah Allen speaks to Anas Sarwar, Labour MSP and former spokesperson for health*

**Dentistry's lobbyist**

Anas Sarwar  
MSP at the  
Scottish  
Parliament  
at Holyrood

**H**ealthcare is arguably one of the biggest political footballs there is: plans for the NHS can influence election results hugely; an NHS funding claim on the side of a bus was the defining image of the Brexit campaign. However, among all the political claims, counter-claims and rhetoric, and the laser-focus on the high-profile healthcare issues of the day, it can often feel that dentistry is the lost specialty. Individual oral health issues are increasingly gaining traction in the political arena, but oral health as a key area of healthcare practice is still conspicuous by its absence in governments' long-term healthcare policy in most UK nations, and funding for dental services continues to fall.

In Scotland, the Oral Health Improvement Plan (OHIP) was launched to great fanfare in January 2018. However, it was not without its detractors who were concerned about some of its core elements. It was felt that although the OHIP was full of action points, most of those actions pledged to investigate or discuss rather than to do, and there has been little visible action

since the launch. Indeed, the biggest development has been the reversal of the OHIP proposal to change the recall period for the majority of patients from six months to up to 24 months. A potential further complication in moving forward has now been added in the lack of a new permanent Chief Dental Officer following the retirement of Margie Taylor.

In light of all of this it seems fair to ask just how seriously dentistry is taken by governments, parliaments and those who influence and drive national healthcare policy.

In the first of a series of interviews in which *Scottish Dental* examines the status of dentistry in our political and policy frameworks, I spoke to Anas Sarwar, MSP for Glasgow, former Scottish Labour spokesperson for health and ex-GDP. Anas sits as a member on a number of health-related cross-party groups and is the co-convener of the cross-party group on cancer. As such, he was a key figure in lobbying to change the Oral Health Improvement Plan proposal for 24-month recall. Between 2010 and 2015 Anas was the MP for Glasgow Central.

**Lack of importance**

I started by asking Anas whether he thought that dentistry and oral health were taken seriously enough in politics and whether they had the profile that they needed to have.

"I think the sad, honest answer is that, more often than not, the industry is perhaps seen as being an easy cut to make. I don't think it gets the profile or level of importance that it deserves or perhaps has received in previous years. I remember when I was a dental student there was a real priority in government around recruitment and retention, particularly for GDPs and for remote areas of Scotland. I think there was a drive to improve the delivery of NHS dentistry services, but I think there's been a creeping neglect of NHS dental services in recent years. I think that's a combination of a lack of importance and engagement at a decision-making level, but I don't think

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**THERE HAS BEEN A CREEPING  
NEGLECT OF NHS DENTAL  
SERVICES IN RECENT YEARS”**

**ANAS SARWAR**







you can give isolated criticisms to the government around that to be frank; I think the profession itself has to have some self-criticism as to how it has projected the importance of dentistry, how it has lobbied the government as to issues around dental practice, and how it has fought its corner.

"I'll give you a practical example. I am an NHS dentist by background, a lot of friends are dentists, my wife is a dentist, so I'm close to NHS dentistry and dentists. But when I was the health spokesperson for the Scottish Labour Party, having done that role for almost two and a half years, I struggle to think of any occasion over that time where we got meaningful dialogue and engagement with the dental profession or lobbying around their priorities and getting a fair deal. I think that's a negative both for the profession and for the people that rely on dental services.

"This is not a criticism that is a secret. I've made it openly to the BDA, for example, about what more I think they could or should be doing to fight dentistry's corner, and I think it has got better in recent months. I think you can see that from the lobbying we did together around the long-term plan for NHS dentistry, particularly the challenges around 24-month check-ups and the challenges around oral cancer."

We'll come back to what more the profession could and should be doing to engage with and lobby parliament, but I wanted to explore whether Anas thought that recent high-profile campaigns, such as 24-month recall, risked becoming causes célèbres, which threatened to obscure dentistry's role within healthcare policy and strategy as a whole.

"I understand and agree with why there was a focus on oral cancer. It

was a very good focus, and I hope we got a good result from it and that there will be a long-term focus on it, but we shouldn't mistake NHS dentistry as purely being a profession where you prod 'em, drill 'em and fill 'em. That is a large part of the job around treating decay and highlighting prevention, but the role of the dentist, particularly at a time when we have such a huge vacancy rate around GPs for example, in our primary care model should be as a genuine partnership within a reformed community care and health services portfolio.

"The biggest thing for healthcare professionals across the board is looking at those individuals who are hardest to reach, particularly in areas of extreme deprivation where there is poverty, high incident rates of heart disease and tooth decay, poor life expectancy, issues with how people live their lives, alcohol and substance misuse. Quite often, for those hardest-to-reach individuals, a click moment can come in their lives, more often than not from an interaction they have with another human being. A dentist could be that click moment.

"How you interact with a patient coming through your door, how you behave with them, how you engage with them, how you treat them, how you give them confidence in themselves and in the treatment you're giving them, could be that click moment, signposting them to other services or making them look at how they live their lives and how that impacts their health and their families.

"If you recognise that dentists have that role as equals with all other professionals around health and social care, that I think will lead to a greater focus on dentistry and dental services. I think that has



to be the focal point for all those bodies that represent dentists."

### Dentists' frustration

Anas has experience in both Westminster and Holyrood, and sits on a wide range of health committees, so I asked him whether he thought it was hard for dental representatives to get a seat at the table and whether he felt dentistry need to be taken more seriously by politicians.

"I remember when I was making a decision about what I wanted to do with my life, my studies and university. I chose dentistry but I'm not sure I would have made that decision now. I think dentistry then was seen as being a more attractive option compared with even general medical practice.

"I'm not sure that's the case now and I think it is partly due to the fact that there has been a loosening focus on the importance of dentistry, and a frustration from dentists around the respect that they're given as a profession, and the place they are given alongside other healthcare professions. That needs to change.

"There is a role for dentists around the clinical aspect but if you are to defend the profession in the interests of the communities you

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I'VE MADE [THE CRITICISM] OPENLY  
TO THE BDA ABOUT WHAT MORE I THINK  
THEY COULD OR SHOULD BE DOING  
TO FIGHT DENTISTRY'S CORNER”



serve, then how you strengthen your representative bodies, how you sharpen your elbows and have the confidence to fight your corner is part of how you can get greater parity with other NHS services.”

What are the potential consequences of this lack of meaningful representation within political policy and strategy making?

“My fear is that there is creeping privatisation in NHS dentistry. There is more and more of ‘let’s make things that little bit more challenging’ so that people will opt to either provide more private dental services or patients will turn more toward private dental services. I think that would be really regrettable and I don’t think that will work for patients, government or dentists.”

It seems we have to accept that there is a significant lack of understanding about the dental profession among politicians, but I was curious to understand whether Anas felt that there was a similar lack of understanding about the role of dental professionals, both as a distinct discipline and within the wider framework of healthcare, with the public and whether there was a role for politicians, influencers and dental professionals to play together to educate people about dentistry.

“Yes, and I think the challenges around general medical practice have brought that into much sharper focus. If you look at the stats, around one in three GP practices in Scotland are reporting a vacancy, and that trajectory looks like things will get more difficult rather than there being any quick solution – you can’t magic up hundreds of GPs overnight.

“To cope with the challenges, the only way is to have a broad-range, multi-disciplinary approach to primary care, changing the culture where people automatically assume that any issue that arises is a matter for their GP. As we look

at service redesign and reform of the NHS to make it fit for purpose for the 21st century, to make it resource and workforce fit, we are going to have to look at developing genuine community care rather than a focus on seeing primary care as being just the GP practice.

“I think another reason we need to do this is that, with an aging population, we are going to see much more demand for services in the community, and as you see greater advancements in healthcare you are getting more and more people who are living longer and with multiple conditions.

“This means you need more generalists rather than specialists, and a push toward people being in their home and community, rather than in social care. If you accept that as happening, then how service is redesigned and how funding and workforce matches that needs to be rethought.”

On this topic, I asked Anas about a key thread, and one of the more controversial aspects of the OHIP, the emphasis on treatment within domiciliary care. I wanted to know if he felt this was really one of the fundamental issues facing NHS dentistry and whether it was just too big to address as things







stood, without significant and sustained financial investment into NHS dental services.

"I think the biggest fundamental issue is, if you match remuneration to purely how many bums you can get on the seat, how many teeth you can drill and fill, and how many individual pieces of treatment you can do, then the focus of that treatment plan and the holistic care we want for every person in Scotland doesn't hang on the individual.

"It becomes about a profession which is purely probe, drill and fill. Dentistry is more than that, which goes back to changing the culture. But you will only change the culture if you set that priority from the top down, in partnership with people in the community, and have the resource model and the workforce model to meet that. I'm not sure we're at that stage yet."

I asked what Anas thought it would take to get to that stage.

"It is really easy for people to think that the biggest problem facing the NHS is money, and I'm not saying money isn't a problem, of course it is, but a more fundamental problem is a people problem. Not that they aren't adequately trained or engaged; I think the greatest thing about the NHS is the people who work in it, but it's about having enough resource to adequately support, and enough people so everyone can do their jobs properly. If there are not enough of you, and you have more work as a result of that, then you lose the time to care. You have to give clinicians the time to care and not just the time to treat."

The conversation then moved to the OHIP. One of the criticisms levelled against the OHIP has been that it, in Anas's own words, "promises a lot of thinking".

"There comes a point where you need to stop reviewing and thinking, and start actually doing. I think there is a direct correlation between someone's oral health, their self-confidence and their life outcomes and life chances. It is no coincidence that the areas where you see the highest levels of poverty and deprivation and unemployment are also the areas where you see the poorest levels of oral health. It is a sad reality of life that people are judged on more than just their ability, they are also judged on their appearance.

"Would you ever have a First Minister, for example, who



## THERE COMES A POINT WHERE YOU NEED TO STOP REVIEWING AND THINKING AND START ACTUALLY DOING"

had missing front teeth or had severely decayed teeth or didn't have an aesthetic smile? You wouldn't and, if we accept this correlation, that in itself is a reason to recognise why dentistry has an important role to play.

"It goes back to my point about the click moment and that for many of the most hard to reach people, their interaction with their dentist may be the only interaction they have with any healthcare professional."

It is easy to agree that dental professionals have a crucial role in reaching the hard to reach, but I wanted to understand more about whether Anas believed the OHIP supported this critical role, or whether key groups were lost within the Plan. One example is the issue that individuals can often fall off a cliff as they age, getting lost in the system, ceasing their regular or semi-regular contact with their dentist and only appearing again in the system once in domiciliary care. It seems to be a big gap in the OHIP and means that patients with complex

requirements are going to be seen by dentists with whom they don't have a relationship. I asked Anas whether he thought this was important?

"The key word is 'relationship'. That relationship between clinician or professional and the individual is really crucial. I know from my own experience that I built a relationship and a trust with my patients which meant they would talk to me about more issues than what was going on in their mouth, and I felt more confident in asking them about problems they were having and how that related to their healthcare. That human interaction is an important part of delivering effective, respected and quality healthcare. That has to be a fundamental principle."

### GDC relationship

One issue that dentists have regularly raised with Anas is relationship between the profession and the GDC, and he was anxious to raise this. In this magazine, I have been critical of the GDC and the culture of fear that seems to have been generated around them, so I was interested to hear whether Anas felt that criticism was justified, based on his conversations.

"The relationship between the GDC and the profession seems to be one of policing rather than partnership. There is of course a role for policing and investigation to ensure there is quality, but if even Police Scotland believe that the future of policing is through being a partnership with their communities rather than purely policing their communities, and I'm hopeful that the GMC recognises this too, then I think that the GDC has to have







that same thought and culture change as well. I think that is a more effective future model and I will take it up with the GDC shortly.

“The bottom line is that there are probably individuals within the GDC who want to create a culture of fear, but I think that is a very naïve approach to take and actually undermines the profession and undermines the point of the GDC. If we want clinicians to respect the profession and their patients and, crucially, recognise when they get it wrong and have the confidence to recognise when they get it wrong, then having the body that oversees them being in partnership is really important.

“Dental professionals are public servant who have dedicated their lives to caring for other people. I’m not suggesting that some of them don’t get things wrong or there are instances when it is right that the GDC steps in and takes tough action, but you don’t tar every professional with the same brush, so I would say to the GDC, create a partnership rather than a culture of fear.”

### **Privilege and honour**

To finish, I asked Anas whether there was anything else that had particularly struck him about the dental profession’s interaction with the political world and whether he had any final piece of advice as to how it could raise its profile and importance in parliament.

“Don’t think it is someone else’s job. If dentists think it is someone else’s job to go and make the argument and make the case for dentistry, then I fear they’ll get left behind. Yes, be true to your profession, work hard in your profession and in your role as a clinician, but don’t lose sight of the importance and strength of your representative bodies and the ability to advocate for the long-term benefit of you and your profession.

“To get a place in dental school, to be a qualified professional, to have meaningful employment is a privilege and an honour and I think that privilege and honour extends beyond just the remuneration value and the impact on your family.

“The largest privilege and honour is that you are in a position to care for your fellow citizens. If you see it as that privilege and honour, then you have a duty not just to practice the profession but to protect that profession as well.”



*An entrenched culture of bullying and harassment within the NHS workplace is taking a toll on the wellbeing of employees and is having a serious impact on the effectiveness of healthcare services. The clamour for more concerted action to tackle unacceptable behaviour is growing*

WORDS  
TIM POWER

# *An assault* on dignity

**B**ullying within the workplace can take many forms, including verbal, non-verbal, psychological or even physical abuse. It can involve rudeness and constant arguments as well as unacceptable criticism, and situations where people are overloaded with work, ignored or isolated from others. It not only has a detrimental effect on people's wellbeing but on their work performance as well... and that's when it becomes a major issue for both healthcare services and patient care.

In recent years the focus of bullying has moved beyond the schoolyard and internet into the workplace, with particular emphasis on people working in healthcare settings. Although there are, as yet, no studies of bullying in the dental sector specifically, the issue is highlighted in a number of NHS-related studies and surveys, which

## Examples of bullying behaviour

(source: [www.rcn.org.uk](http://www.rcn.org.uk))

- › Sadistic or aggressive behaviour over a period of time
- › Excluding people from meetings for no good reason
- › Humiliating or ridiculing others or criticising others in public
- › Persistent, unwarranted criticism of others in private
- › Treating colleagues as if they were incompetent
- › Changing work responsibilities or academic assignments unreasonably or without justification
- › Regularly changing work deadlines or work guidelines without warning
- › Deliberately withholding information to affect a colleague's performance
- › Withholding support in the academic environment or workplace
- › Cyber bullying conducted via social networking channels.

This list is not exhaustive: remember, bullying is any behaviour that is unacceptable to you or makes you distressed.

include feedback from NHS dentists.

Extensive research by academics has shown the adverse impact of bullying and harassment on the wellbeing of employees in care settings and on the quality and safety of care they provide. Staff affected by bullying can experience a range of different emotions such as upset, anger and isolation which can lower their motivation, confidence, self-esteem and resilience and develop into more serious mental health conditions such as anxiety, stress and depression.

In some cases, subjects of bullying have shown symptoms of post-traumatic stress disorder. In addition to causing a range of serious health impacts, research has shown that people subjected to bullying are less likely to work in effective teams, raise concerns or admit mistakes – and this has potentially serious consequences for patients.

This situation has alerted the UK Government to the dangers of bullying, both for staff wellbeing and patient treatment. Health Minister







Stephen Barclay announced recently that he wanted the “fit and proper” person test for NHS directors, which was introduced in 2014, to be widened to require action on harassment and discrimination. This was on the back of the care scandal at the Mid Staffordshire Hospital Trust and the results of the latest NHS staff survey which show that one in four employees had experienced bullying, harassment or abuse.

### Long-standing culture

In Scotland, NHS Highland is under investigation for an alleged “long-standing bullying culture” after four doctors raised their concerns with a newspaper that the working environment was damaging patient care.

Examples such as this, along with NHS staff surveys that also capture feedback from dental professionals, led British Medical Association (BMA) Scotland council chair Lewis Morrison to warn about the repercussions for patient care in his recent Christmas and New Year message if the “scandal” of a culture of bullying and harassment was allowed to thrive in the NHS.

He said the BMA would launch a major initiative in 2019 to understand doctors’ experience of this unacceptable behaviour, to probe causes, and find solutions. He was also calling on other stakeholders, including the Scottish Government and NHS managers, “to work together to make Scotland’s NHS a more positive place to work”, and was planning a summit for early

summer. A recent BMA survey of its members (BMA Scotland 2018 Membership Survey) revealed that almost four in 10 (38 per cent) say that bullying and harassment is an issue in their workplace.

Dr Morrison said: “Doctors have told us that bullying and harassment is still widespread and recent high-profile cases only serve to underline those concerns. Ultimately, the levels of bullying and harassment we currently see in Scotland’s NHS can only have serious negative repercussions for the care it provides.”

This concern is mirrored south of the border too from the results of the 2017 NHS England staff survey that shows no substantial movement from the previous year in the measures of bullying, harassment and abuse against staff, whether by patients and relatives (28 per cent) or by managers and other staff (24 per cent).

Of the 30,000 doctors and dentists who responded to the NHS England staff survey in 2016, 24 per cent reported that they experienced some form of bullying or harassment in the preceding year: 13 per cent of doctors and dentists said they had been bullied or harassed by their manager, while 16 per cent said they had been bullied or harassed by another colleague.

According to this survey, only a minority of doctors and dentists who experienced bullying or harassment reported it to their employers. The report suggests that bullying will often go unchallenged, particularly among trainees. For example, only 27

per cent of trainees who experienced bullying and harassment said they or a colleague had reported it, compared with 33 per cent of consultants and 36 per cent of other specialty and associate specialist grade staff.

Constant bullying and harassment not only takes a toll on the wellbeing of employees but on the effectiveness of healthcare services. A recent study on the impact of bullying in the NHS in England put the cost at £2.281 billion based on sickness absence, sickness absence costs to the employer, employee turnover, diminished productivity, sickness presenteeism, compensation, litigation and employment relations costs. The biggest financial impact is from sickness presenteeism due to bullying, costing £604.4m a year – this is the productivity lost when staff come to work while being bullied.

Despite the serious impact on healthcare services there is no law specifically against bullying. However, under the Health and Safety at Work Act 1974 employers do have a duty to ensure the health, safety and welfare of their employees, which can be compromised by bullying and harassment.

Bullying may be characterised as offensive, intimidating, malicious or insulting behaviour, an abuse or misuse of power through means intended to undermine, humiliate, denigrate or injure the recipient. Harassment, however, is defined in the Equality Act 2010 and relates to unwanted conduct affecting the dignity of men and women in the workplace. It may be related to age, sex, race, disability, religion, sexual orientation, nationality or any personal characteristic of the individual, and may be persistent or an isolated incident. The key is that the actions or comments are viewed as demeaning and unacceptable to the recipient.

In the workplace, bullying and



**DOCTORS HAVE TOLD US THAT BULLYING AND HARASSMENT IS STILL WIDESPREAD AND RECENT HIGH-PROFILE CASES ONLY SERVE TO UNDERLINE THOSE CONCERNS**

**DR LEWIS MORRISON**

harassment can come from managers to their subordinates or from individual colleagues or groups of people, but patients can also present bullying behaviours, particularly if their expectations have not been managed and they threaten legal action.

As the NHS surveys illustrate, very few people subjected to bullying and harassment formally report it. In its recent report on workplace bullying and harassment of doctors, the BMA highlights factors identified as likely to lead to a bullying culture, such as autocratic, target-driven management styles, poor job design, work intensification, and pressures arising from restructuring or organisational change, especially when radical and top-down. Another factor they raise that can lead to a bullying culture is the hierarchal nature of the medical profession which, along with workload pressure, can increase the likelihood of 'silent bystanding' – a failure of colleagues to speak out – which allows bullying behaviour to continue unchallenged.

In its report, the BDA is calling for more comprehensive organisational approaches that focus on ensuring work wellbeing and good workplace relations so that behaviours like bullying do not arise.

Unsurprisingly, there are a number of high-profile campaigns and initiatives designed to tackle bullying cultures within healthcare that have been launched as the scale of the problem has become evident. One of these is the Royal College of Surgeons of Edinburgh (RCSEd) #LetsRemoveIt campaign which has brought together groups across different healthcare specialties.

It was launched after the college's own membership survey showed that nearly 40 per cent of respondents reported that they had been victims of such behaviour, with the same amount reporting that they

had witnessed it.

The RCSEd has collated a suite of resources on its website to help people to understand and identify bullying and harassment and speak up and report it. It also includes a number of reflective resources for managers to consider for their own actions (see panel below) and also advice on how to be assertive without being a bully: by keeping goals level-specific rather than personal.

It must be recognised that some people, particularly managers, may not realise or perceive that they are behaving like bullies and that their conduct is seen by others as unacceptable. They are often highly competitive and successful people who thrive in a different work value system and may not be conscious of the sensitivities of the people they work with. The stresses at work can also cause people to behave differently, and that behaviour becomes reinforced until it becomes 'acceptable' and part of the culture in the healthcare setting. That is why it is important for people to respectfully challenge these behaviours and make it clear to the 'bully' that their behaviour is unacceptable.

On its website, the NHS advises people who believe they are being bullied at work to first seek informal advice from a trusted colleague in order to discuss how they might deal with the problem – by sharing experiences with others they may discover that it is happening to other people too.

Other people to consider raising the issue of bullying with include a manager or supervisor (if that is suitable), someone in the organisation's human resources department or an employee representative, such as a trade union official. If the bullying is affecting someone's health, then they need to visit their GP.

## NHS advice on dealing with a bullying situation:

### Be strong

Recognise that criticism or personal remarks are not connected to your abilities. They reflect the bully's own weaknesses, and are meant to intimidate and control you. Stay calm, and don't be tempted to explain your behaviour. Ask them to explain theirs.

### Talk to the bully

The bullying may not be deliberate. If you can, talk to the person in question, as they may not realise how their behaviour has affected you. Work out what to say beforehand. Describe what's been happening and why you object to it. Stay calm and be polite. If you don't want to talk to them yourself, ask someone else to do it for you.

### Keep a diary

This is known as a contemporaneous record. It will be very useful if you decide to take action at a later stage. Try to talk calmly to the person who's bullying you and tell them that you find their behaviour unacceptable. Often, bullies retreat from people who stand up to them. If necessary, have an ally with you when you do this.

### Make a formal complaint

Making a formal complaint is the next step if you can't solve the problem informally. To do this, you must follow your employer's grievance procedure.

### What about legal action?

Sometimes the problem continues even after you've followed your employer's grievance procedure. If nothing is done to put things right, you can consider legal action, which may mean going to an employment tribunal. Get professional advice before taking this step.

### Other resources on bullying:

- › GOV.UK: workplace bullying and harassment
- › [www.nhs.uk/conditions/stress-anxiety-depression/bullying-at-work](http://www.nhs.uk/conditions/stress-anxiety-depression/bullying-at-work)
- › Acas helpline
- › Citizens Advice: problems at work
- › Equality and Human Rights Commission (EHRC)
- › Royal College of Surgeons of Edinburgh  
<https://www.rcsed.ac.uk>

### Here is a checklist to help you think about how your behaviour might impact on others (source: [www.rcsed.ac.uk](http://www.rcsed.ac.uk)):

- › Do you listen to the other members of your team or do you do all the talking?
- › Do members of your team come to you with ideas or suggestions?
- › Does your sense of humour involve jokes that could be racist, homophobic or sexist?
- › Do you feel that 'you had it tough so they should too'?
- › If you are senior, do you use your position to offer mentorship or do people go to others for this?
- › Do you always apologise to someone if you lose your temper?
- › Have you written derogatory comments about someone on WhatsApp, Facebook or Twitter?
- › Do your colleagues look you in the eye?
- › Do you ignore any of your colleagues?
- › Do you blame others for problems that occur?
- › Do people speak freely in your theatre / clinic or do you dictate how people behave?
- › Does banter form a big part of your interactions with others?
- › Have you ever fired off an angry email?
- › Do you prefer to email colleagues about difficult situations, rather than discuss things face-to-face?

WORDS  
NIALL NEESON

HOW TO FIGHT

# 'FIGHT OR FLIGHT'





# HOW

does it make you feel when your receptionist informs you that “this next patient is REALLY nervous”?

Dental anxiety is something we all encounter on a daily basis. It won't surprise you to hear that it can cause significant stress for both patients and dentists<sup>1</sup>.

In Ireland it has been shown to cause problems for up to one in five adults<sup>2</sup>. Remember, this represents a big chunk of our patient base. At times it can seem inconvenient to take extra time for nervous patients but there are huge benefits in managing dental fear effectively – for patients and indeed for us.

There are many factors that can contribute to dental anxiety including genetic or personality factors, mental health and parental influence<sup>3</sup>, and it has been shown to be a lot more complicated than the typical bad experience from ‘The Butcher’.

In spite of this, when anxious or phobic patients are asked, they do often speak about a particularly memorable experience – often painted in colourful language vividly describing the sights, sounds, smells and sensations. Sound familiar?

Realistically, despite our best efforts, we have probably all contributed to such experiences in the past. But what can we do to reduce the chances of contributing to dental anxiety in the future?

Well, while ‘fear’ is a normal physiological response to a real or imminent danger, anxiety is different; anxiety is a response to a ‘perceived’ threat at a time when there is no objective source of danger. Anxiety will activate the sympathetic nervous system, release adrenaline and cause those familiar ‘fight or flight’ symptoms.

Importantly, if a ‘perceived threat’

is allowed to develop into a panic attack then the brain will determine it to be a ‘believed threat’. In the future the brain will then treat it as a real and justified fear, becoming more of a challenge to both patient and dentist (if the patient did ever come back, that is).

Thankfully, this is where we can help.

How? Well, firstly we need to adapt *our* perception of these fight or flight symptoms. We need to recognise them as a warning sign rather than a hindrance, a sign that we need to do something in order to nip it in the bud for the patient. In doing so we have the power to prevent it from progressing to a full-blown panic attack that will result in a lasting effect.

The good news is that there are lots of quick and simple techniques we can all use to achieve this – we can turn off the adrenaline tap and help the patient to calm down.

Special techniques such as systematic desensitisation, cognitive behavioural

turn these potentially challenging scenarios into practice builders and good reviews.

**1)** Set the tone. Think about the music, ambience and smell. Consider how your surgery looks to an anxious patient and what can be done to make it more welcoming and less threatening. Adapting the environment with slow, relaxing music<sup>5</sup> and essential oil vapourisers<sup>6</sup> can help to bring down the energy of the room and reduce patient apprehension.

**2)** Respect the biology of the fight or flight response. We're all from a scientific background and understanding. We all know the sympathetic nervous system leads to tachycardia, sweating and shortness of breath, but other symptoms can affect communication and an actual biological increase in pain perception<sup>7</sup>. Simply having an understanding and appreciation of this can reduce our frustration



## WHAT CAN WE DO TO REDUCE CONTRIBUTING TO DENTAL ANXIETY IN THE FUTURE?

**NIALL NEESON**

therapy (CBT) or hypnosis are fantastic but can require a lot of time, effort and training<sup>4</sup>. It has been shown that for the majority of patients simple measures can be applied to manage concerns and fear<sup>4</sup>. These are things that all of us can (and probably do) apply such as distraction and simply providing information.

Here are six simple tips that don't require any extra time or cost but can make a real difference. Help

and stress levels. So the next time a petrified patient asks you the same question for the third time, just bear this in mind. And teach this to receptionists and nurses – their attitude has the power to make it or break it for nervous patients.

**3)** Listen to their story. They have rehearsed it. Meeting a new dentist is a big deal for them, and they are telling you that they don't want the same thing to happen again. Actually



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listen for clues as to what's important to them and re-assure why your practice is a safe place to be. Knowing that the same thing will not be allowed to happen again will instantly reduce the adrenaline release and will help them to settle and trust you.

#### 4) Provide a sense of control.

Research shows the importance a sense of control has for the anxious patient<sup>8</sup>. A simple but clear stop signal goes a long way. Lifting the hand can work fine. I like to use a button clicker – psychologically it gives them a sense of having the power to stop us 'in the palm of their hand.' Believe it or not I use the type that are used to train dogs! Not very glamorous but patients love it.

5) Open your eyes. A wonderfully simple but effective technique that I picked up from Mike Gow in Glasgow. Typically when a fearful patient knows the injection is imminent they close their eyes, maybe even scrunch up their face or clench their fists. As 'fight or flight' kicks in, they then begin a process of visualising in their own minds how horrifically long and sharp your dental needle is and imagine the extent of pain it will inflict upon them. This sort of catastrophic thinking and expectation probably contributes to the fact that anxious patients do actually feel more pain<sup>9</sup>. A superb distraction technique is simply to ask them to open their eyes just before the injection. As this unexpected command leaves the patient trying to figure out why on earth they have to open their eyes, it completely disturbs the spiral of negativity in their minds and also floods the brain with visual sensory input to process.

6) Slow breathing techniques. I like to follow "Open your eyes" with a focus on slowing down the breathing. Unless you're into mindfulness or meditation, it may seem a little bit silly the first few times you use it but give it a go – trust me, it works really well. Something along the lines of "one way of helping to feel more relaxed is to take big, slow deep breaths in, to fill up your lungs like a balloon...(you inspire)...and then really slowly breathe out, as though there's just a small hole in the balloon to let the air out". A focus on the action itself along with the visualisation act together as an effective distraction. At the same time the control of breathing actually



slows down the physiology, reducing heart rate and allowing the patient to feel more in control and less panicked<sup>1</sup>.

These techniques combine beautifully to achieve our goal of upsetting the surge of adrenaline release and successfully fighting the fight or flight.

Now, we know a certain proportion of patients won't even get as far as the surgery never mind the chair and for those patients sedation or CBT are likely to be a more productive approach. But whereas these truly phobic patients are in the minority, techniques like this will apply to everyone and can only help improve their perception of a visit to your practice.

You might be surprised how well they work. So go on, give them a go – for everyone's sake.

Research has shown the importance of a sense of control has for the anxious patient

**“A SUPERB DISTRACTION TECHNIQUE IS SIMPLY TO ASK THE PATIENT TO OPEN THEIR EYES JUST BEFORE THE INJECTION”**

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# First bite syndrome: What every general dental practitioner should know

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## ABSTRACT

First bite syndrome is an uncommon complication following surgery involving the infratemporal fossa and the parapharyngeal space or deep lobe of parotid. We report a case of first bite syndrome that was referred to our unit in an effort to make GDPs aware of the presentation of and to highlight the management of this potentially debilitating chronic pain syndrome.

CPD/Clinical relevance: This paper describes how first bite syndrome may present as a complication following surgery; general dental practitioners should be aware that it may represent the initial presentation of an underlying neoplastic process of the parotid gland or parapharyngeal space.

Objective: The reader should understand the presentation and management of first bite syndrome. The role of a GDP is important in management and potential diagnosis.

## Concise precis

General dental practitioners (GDPs) should be aware of the typical clinical presentation of first bite syndrome and refer appropriately to oral and maxillofacial surgery.

## Introduction

First bite syndrome is an uncommon complication following surgery involving the infratemporal fossa and the parapharyngeal space or deep lobe of parotid<sup>1</sup>. Patients typically experience pain in the parotid region on the same side as the surgery at the first bite of each meal. It characteristically lasts for a few seconds and gradually improves

with subsequent mastication, but returns at the first bite of the next meal<sup>2</sup>. Symptoms range from mild to severe, and can significantly affect the patient's quality of life<sup>3</sup>.

The actual cause of first bite syndrome is unknown. Most cases occur as a postoperative complication, but it has also been reported preoperatively<sup>3,4,5</sup>, and even spontaneously, without any obvious cause<sup>6</sup>. Most theories on the pathology of first bite syndrome are based on the concept of sympathetic denervation of the parotid gland either through cervical sympathectomy or ligation of vascular structures alongside which sympathetic nerves

travel<sup>3</sup>. This results in subsequent hypersensitivity of myoepithelial cells to parasympathetic neurotransmitters and elicits a supramaximal contraction of myoepithelial cells during the first bite of a meal and subsequently subsides with continued mastication<sup>7</sup>. We report a case of first bite syndrome which was referred to our unit in an effort to make GDPs aware of the presentation of and to highlight the management of this potentially debilitating chronic pain syndrome.

## Case Report

A 50-year-old female initially presented to the ear, nose and throat team with





**Figure 1:** Surgical scar left side of neck from previous neck surgery

a left-sided level II neck mass, which had slowly increased in size over a six-year period. Medically she was fit and well, and a non-smoker. Three years previously she had undergone a mandibular advancement osteotomy with insertion of a chin prosthesis for a high angle Class II Div I malocclusion and had made an uneventful post-operative recovery.

Magnetic resonance imaging (MRI) and ultrasound guided fine needle aspiration cytology were suggestive of a benign neuroma most probably arising from the vagus nerve. She proceeded to have surgical excision of the lesion, which was histologically confirmed as a Schwannoma, most likely arising from the ansa cervicalis. At a subsequent review appointment two months after her surgery she complained of pain over the left side of her face around her temporomandibular joint (TMJ) and she was noted to have mild Horner's syndrome on the left side.

The patient was referred to oral and maxillofacial surgery querying TMJ dysfunction. She complained of severe shooting pains over the left side of her upper neck, angle of her jaw and around her TMJ on the left. Pain was reportedly worse on biting and eating, especially with the first bite of a meal. She did not

complain of any background pain and felt she could relate the onset to her previous neck surgery.

Clinical examination revealed a scar over the left side of her neck in keeping with her previous neck surgery (Figure 1). She was tender over the left TMJ to palpation, it had a full range of movement which was pain free. There was also some tenderness noted over the muscles of mastication on the left side. Intra oral examination revealed no obvious source for her symptoms and although she had amalgam restorations in her upper and lower molars on the left (Figure 2) none of her teeth were tender to percuss or elicited an abnormal response to sensitivity testing. Orthopantomogram revealed thin condyles only with no obvious dentoalveolar pathology. A computed tomography scan showed mild thinning of the condyles with no evidence of pathological deterioration. A diagnosis of TMJ dysfunction was made and it was felt this may have been a complication of her previous mandibular advancement surgery three years previously. Initial management was conservative with advice on analgesia, soft diet, warm compress and myotherapy of the muscles of mastication.

At subsequent review appointments the patient reported a mild improvement in symptoms while following conservative measures. However, the history became clearer that the sharp pain she was having had occurred with the first bite of each meal and eased with subsequent bites. In addition the pain was worst with the first meal of the day. She also reported no background pain. A clinical diagnosis of first bite syndrome was made and was supported by the established association between this condition and Horner's syndrome. It was felt that this was most likely a complication of her previous neck surgery for her schwannoma. An MRI was performed to exclude any other lesions which may give rise to first bite syndrome. She was initially treated with non-steroidal anti-inflammatory drugs (NSAIDs) and gabapentin. However, this failed to control her symptoms. Following a review of the literature she was commenced on carbamazepine and the dose titrated to effect<sup>7</sup>. She was able to tolerate a dose of 400mg daily but was concerned that any higher dosage would make her feel overly drowsy. Her symptoms were less severe and better controlled on carbamazepine, the pain on first bite was not as extreme and settled much quicker with subsequent





**Figure 2:** OPT showing heavily restored posterior molars bilaterally but no dentoalveolar cause for her symptoms.

mastication. We discussed the injection of botulinum toxin into the left parotid gland as a treatment option<sup>8,9,10</sup>, but she declined this. The patient remains under outpatient follow-up, and feels that her symptoms are tolerable at present.

### Discussion

Surgery which involves extensive dissection in the parapharyngeal space is associated with multiple complications due to the complex neurovascular anatomy within this region<sup>10</sup>. Complications such as vocal cord palsy, palatal weakness, and Horner's syndrome may be expected due to essential sacrifice of nerves involved in the sacrifice. A less predictable complication of these surgeries is first bite syndrome. The proposed pathophysiology behind this was originally described by Netterville et al<sup>11</sup> in 1998. It is believed that sympathetic innervation to the parotid gland is either damaged or lost in the extended dissection of the external carotid artery where these fibres run. Loss of sympathetic input leads to hypersensitivity of sympathetic receptors on the myoepithelial cells of the parotid gland. Cross-stimulation of these receptors by parasympathetic release of acetylcholine is believed to cause a hyperintense contraction of these myoepithelial cells which results in the pain described by patients in the first few bites of their meals<sup>10</sup>. This

is the rationale for the treatment with intraparotid injections with botulinum toxin as it blocks acetylcholine, and this blockade of neurotransmitters decreases the intense myoepithelial contractions derived from the cross-stimulation of sympathetic receptors, in doing so relieving the pain experienced on initiation of mastication<sup>9</sup>.

Most reported cases of first bite syndrome have been documented after surgery; however, in the absence of ipsilateral upper neck surgery it may be the first presenting symptom of a malignancy of the deep lobe of parotid, submandibular gland or ipsilateral parapharyngeal space<sup>3,4,5,12</sup>. It has also been reported as idiopathic first bite syndrome in patients without a history of surgery or without any evidence of neoplasia<sup>6,13</sup>. General dental practitioners should be familiar with this chronic pain syndrome as patients may present to them in the first instance relating their pain to biting and attributing it to an underlying dental pathology.

The diagnosis can be made by taking a good history and by thorough clinical examination. It presents clinically as an intense, paroxysmal, electric shock, cramping or spastic pain arising in the region of the parotid gland or TMJ which rapidly spreads along the mandible<sup>14</sup>. It is triggered by chewing, swallowing or even by simple contact with food, the trigger varies, it may be

solid or liquid foods but is always acidic. The symptoms may be reproduced by stimulating salivary flow via intraoral lemon glycerin swabs<sup>13</sup>. This pain only lasts for several seconds and tends to wane with subsequent swallows, but it recurs after pausing for several minutes or at the following meal. It is also reported to be most severe with the first meal of the day. Some patients find that manual compression of the painful region helps to relieve pain, leading them to press over the painful region preventively before taking the first bite<sup>14</sup>. The onset of the pain may be preceded by ipsilateral upper neck surgery, parotid surgery or orthognathic surgery.

Careful extra oral examination may reveal a surgical scar in keeping with previous cervical neck (Figure 1) or parotid surgery. Deep palpation should be systematic and thorough to exclude any new neoplasia or neck mass presenting as first bite syndrome. Examination of the TMJ should be performed and would be expected to be unremarkable. Another extra oral sign that may arouse suspicion is evidence of Horner's syndrome, pupil constriction (miosis), ptosis and ipsilateral loss of sweating (anhidrosis). This may be a post-surgical complication also, or arise suspicion of a new lesion of the superior cervical ganglion or sympathetic branches travelling along the internal carotid artery. As with any dental patient

careful intra oral examination should be performed to exclude any dentoalveolar cause for the patient's symptoms. The occlusion should be assessed carefully, especially if any recent restorative work has been carried out, heavily restored teeth should have percussion testing and sensitivity testing performed and where appropriate radiographs taken.

In the absence of any clear dental pathology, and with a history that arouses suspicion of first bite syndrome, any dental treatment should be avoided, and the patient should be referred onwards to the closest maxillofacial surgical unit or ear, nose and throat department for further investigation and to initiate treatment. The dentist should be sympathetic and recognise that this chronic pain syndrome can have a considerable impact on the patient's quality of life. The patient may become anxious even at the idea of having a meal and may modify his or her eating behaviour.

Multiple treatments have been attempted to control the pain of first bite syndrome, but few have been successful in completely resolving it. Treatments can be divided into four main categories: dietary modification, pharmacological treatment, radiation therapy and surgical treatment. Dietary modification has been found to be completely ineffective<sup>10,11</sup>. First-line treatment often consists of NSAIDs used as analgesics in combination with anticonvulsants such as carbamazepine or calcium channel blockers, such as gabapentinoids, or tricyclic antidepressants with anticholinergic effects, such as amitriptyline<sup>14</sup>. Although some pharmacological

options have been reportedly effective, most notably carbamazepine and pregabalin<sup>10</sup>, it appears that responses to all these medications varies between individuals<sup>15</sup>. Radiation therapy has been proposed as a viable treatment for first bite syndrome in relation to oncology patients<sup>16</sup>. The side-effects of radiotherapy, however, are numerous and the morbidity associated with it means it cannot be justified for the treatment of first bite syndrome alone when safer modalities exist.

Permanent solutions to first bite syndrome have been sought by surgical means, but these also come with a risk of morbidity. Total parotidectomy appears to be the most effective surgical intervention. However, it is also the most radical and is most notably associated with the risk of injury to the facial nerve. It has been associated with complete resolution in several cases<sup>3,4,5</sup>. Less radical surgical interventions such as tympanic neurectomy have been reported as unsuccessful<sup>18</sup>. Amin et al 2014 describe treating a case of first bite syndrome refractory to non surgical management with laser tympanic plexus ablation, they achieved resolution of her symptoms at three-week and two-month follow-up. Netteville et al 1998 reported auriculotemporal nerve resection to be effective initially but the long-term efficacy is unknown.

More recently many authors appear to favour the use of botulinum toxin injections into the parotid gland and have argued pharmacological measures should be skipped in favour of this as first-line treatment<sup>10</sup>. Lee et al 2009 noted significant improvement but not

total relief of symptoms using 33 units of botulinum toxin injected into the ipsilateral parotid gland. Ali et al 2008 and Sims and Suen 2013 reported complete resolution in three out of four patients treated with injection of 75 units of botulinum toxin into the ipsilateral parotid gland. The other patient had almost complete relief of symptoms with significant improvement in quality of life. The symptoms were found to begin to return gradually within three to five months and patients did not seek further injection until five to eight months<sup>10</sup>. There were no side-effects of the injection treatment reported.

## Conclusion

First bite syndrome may present as a complication following surgery to the parapharyngeal space or deep lobe of parotid. However, GDPs should be aware that it may represent the initial presentation of an underlying neoplastic process of the parotid gland or parapharyngeal space. It has also been reported as idiopathic without any cause found. Patients may attend their GDP in the first instance as they attribute the symptoms to underlying dental pathology. A thorough clinical history and examination is diagnostic and suspected cases should be referred appropriately. Treatment options have a variable effect and often only work in the short term. Further investigations into the pathophysiology of this chronic pain syndrome and pharmacological treatment for first bite syndrome are essential in order to improve understanding and manage this condition more effectively.

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# ASK YOURSELF 'ARE YOU ASKING THE RIGHT QUESTIONS?'

*When it comes to interviews, make sure they're relevant to the job description ... and you'll get the answers you want to hear from the candidates*

[ WORDS: SUSIE ANDERSON SHARKEY ]

## ONE OF THE BIG PLUS SIDES TO

social media in recent years has been the comparative ease of networking with colleagues in what has up until now seemed a pretty lonesome road much of the time where practice managers are concerned.

Facebook networking forums continue to be a great source of linking with other like-minded colleagues in the industry and, in particular, the many and varied practice manager forums that have opened up. It was while browsing one such forum recently that I came up with the topic for this month's article. A lady had commented on the forum that they were hiring a deputy manager and were looking for advice on what questions to ask at interview. Having written previously under the title 'The art of the interview', I thought this could be a good follow-up to that earlier article.

To start with, the position of deputy manager will differ from practice to practice. No two practices are the same and each practice is run differently. Thankfully most dental practices nowadays have a practice manager, whether this be full-time or a manager who divides his/her time between surgery (clinical) and admin (non-clinical). However, it's much rarer to have a deputy manager, someone who will stand in for the manager when they are either ill, on holiday or away from the practice.

In deciding what questions you want to/ need to ask a prospective deputy manager candidate, you must first ask yourself what tasks you will require them to undertake?. What level of responsibility do you plan on them having? There's no point in asking a question that is totally irrelevant to the job description, so first and foremost you need to write a job description with the roles and responsibilities of a deputy manager in your practice. After having written the job description, you will have to think of what skills and attributes are required for the

role. Once you have these fundamentals in place, you are in a much stronger position of compiling a list of questions which will hopefully elicit answers that will let you know whether the candidate is right for the job. Let me give you an example.

One of the questions you have compiled is "Give me an example of a time when you have had to manage conflict between two members of staff and what was the outcome?" You ask the question and the candidate looks a bit flustered and admits that they haven't actually had to manage conflict. And the reason they are flustered isn't because of the question but because "managing conflict" was never mentioned as being part of the remit of the deputy manager. If it's nothing to do with the remit and it's not relevant then don't ask the question, and furthermore don't penalise the candidate if they don't have experience in a field in which they are not expected to work.

Of course, there are general questions that are always good to ask to get the

interview rolling, such as:

"Why do you wish to be considered for this role?"

"What attributes and qualities can you bring to the position?"

"What have you done to prepare yourself for this interview?"

"We have another four candidates, why should we hire you instead of the others?"

"What do you know about our company?"

These are all pretty generic questions that can be used to interview for any position. They are a good starting point for getting the candidate

into the way of answering your questions and provide some general insight into the candidate before moving onto the questions that pertain to the particular job in hand.

So, to summarise:

- Use the job description to formulate the interview questions.
- Keep the questions relevant to the position.
- Start with a couple of generic questions to help to put the candidate at ease.

And finally (and this is the fun part), by all means pitch a curve ball at the end. Ask the candidate something they're not expecting. At a recent interview when it got down to the final two candidates I posed the question to them "What would you do if you walked out of here and found £1,000 on the pavement?" It may seem a totally irrelevant question, but I wanted to see how they reacted when they were taken off guard and posed with a moral dilemma. The funny thing is, when I asked a number of members of staff the same question, not all of them gave the "correct" answer!

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



“  
**AND BY ALL MEANS PITCH  
A CURVE BALL AT THE END.  
ASK THE CANDIDATE  
SOMETHING THEY  
ARE NOT EXPECTING**”

# GET AHEAD. START YOUR 2020 VISION NOW

*There's more to resolve and resolutions than wishing and hoping. Dentistry has become far more proactive and it's time to plan much further ahead*

[ WORDS: ALUN K REES ]

## MY GRANDMOTHER DESCRIBED

New Year's Resolutions as "piecrust promises – easily made, easily broken". With dawn of 2019, probably with similar resolutions for many of us, now is the time to start looking further ahead.

So. What is your 2020 vision?

Imagine it's 1 January 2020. What will have had to happen during the previous 12 months for you to have made good progress in achieving your three and five-year goals?

How is your life looking? What changes and improvements have happened in your career and personal life to make the future better for you and all those around you?

I started this way because there is more to resolve and resolutions than wishing and hoping. Change takes planning, detail, energy and commitment. Unfortunately many dentists tend to take life as it comes, accepting the cards they are dealt. The reason could be because of the historical nature that dentistry worked.

It used to be a reactive career, patients attended when they had problems; the dentist fixed them either with repair or by removing the offending tooth. Eventually when enough teeth had been taken away, false ones were provided.

That model evolved as hygiene improved and we trained patients to attend routinely for "check-ups", the dentally aware mostly kept their teeth for life, but we were still reacting to disease.

For many, the game has changed, and dentistry has become far more proactive,

patient driven and elective in lots of ways. It can still sink into the six-month cycle, or rut, if you allow it, and the only difference between the rut and a grave is the depth.

"Many people lead lives of quiet desperation, and die with their song still in them." That line, attributed inaccurately to Victorian Henry Thoreau, remains true today. Neither is his countryman William James wrong with his advice, "To change one's life, start immediately, do it flamboyantly, no excuses."

If either of these aphorisms rings bells for you, it's time to make plans to start a better 2020 by introducing changes, small and large, over the next year.

How to go about it? By taking Steven Covey's advice to "Start with the end in mind", because if you have no idea where you are heading then it's certain that you aren't going to get there. Get going with the positives; take time on your own to describe your life at the start of 2020.

What is your 2020 vision? Using the following eight headers, either write an essay or using bullet points to detail the good things that will be happening – career, finance, family, health and fitness, fun/recreation, friends, personal development and spiritual. Write in the present tense – these things are happening. The areas are taken from a coaching tool, "The wheel of life", which is freely available on line.

I have evolved a professional wheel of life for dentists to help them with the exercise with a business focus. If you would



like a copy, email me. Once the “future self” document is written, it’s time for commitment so share it with those close to you.

Next, start to look at what needs to be done to make progress with your goals over the next three months, the next month, the next week and finally ask yourself what you need to do today to make progress. Every day, revisit your goals and take at least one

“  
**CHANGE TAKES PLANNING,  
DETAIL, ENERGY  
AND COMMITMENT.  
UNFORTUNATELY MANY  
DENTISTS TEND TO TAKE  
LIFE AS IT COMES,  
ACCEPTING THE CARDS  
THEY ARE DEALT**

action which will move you forward.

So far, so good, and all positive. I am not daft enough to think that everything will be 100 per cent positive; change is never easy, especially if you are introducing changes into a business where others are affected.

The next exercise to help you is to examine your day-to-day life and ask yourself what and where you are tolerating; Thomas J. Leonard described tolerations as “the things that bug us, sap our energy and can be eliminated”.

Leonard said that many of us carry our tolerations around like a noble burden, but it’s an expensive source of self-esteem. Tolerations drain you and inhibit your success, most of us have dozens or even hundreds of them; they can be compromises in life, often things that we don’t realise are weighing us down until they are removed.

Next exercise is to ask yourself the following five questions. What am I going to stop? What am I going to do less of? What am I going to keep doing? What shall I do more of? What am I going to start doing?

Why doesn’t everybody do this if it’s so easy? Simple answer, because it isn’t easy. Change demands persistence, inertia is easy, momentum is essential for change and that demands starting a stationary object.

Whatever you do, take steps, small, medium or large. Reflect on what you have achieved and measure your progress from the start. Then with hard work and application your 2020 vision will become your reality.

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, speaker, 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.  
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# IT'S THE SALES, STUPID!

*Do you know what it takes to drive and grow a profitable practice?*

[ WORDS: RICHARD PEARCE ]

**G**OVERNMENTS STAND AND FALL BY the economy (many believe), and hence James Carville's now infamous phrase, 'It's the economy, stupid', coined during Bill Clinton's Presidential election campaign of 1992. A practice's success or otherwise, is largely governed by the level of its sales. Here we will discuss why this is and therefore what you need to focus on, to ensure you have a growing, highly profitable practice.

Costs in the practice are highly predictable. The benchmark percentage of costs as a ratio of sales, should be well known to every owner:

<b>Associates</b> .....	<b>45%</b>
<b>Materials</b> .....	<b>7%</b>
<b>Labs</b> .....	<b>7%</b>
<b>Staff</b> .....	<b>19%</b>

You can work out your overhead costs per surgery per day – fixed costs/number of surgeries x working days in the month. £250-£600 per surgery per day (depending on where you are and assuming you pay a market rent/mortgage).

Your biggest cost is staff, and we will assume that you have an engaged and effective team who are paid market rates. It also assumes you have a procurement policy that ensures you receive 'best value' from your other suppliers such as bookkeeper/accountant, digital marketing agency etc.

So now we need to get 'granular' with where the 'sales' come from. This means we need to know every 'producer's', average daily yield/production/gross, call it what you will. We'll call it, ADY. Coupled to this we need to know what our plan membership delivers each month and other revenue streams.

Armed with above numbers we can see that if an associate grosses £500/day (and a

surgery costs £250/day) their contribution is to overheads ..... but that's all!

So, we need to have an ADY target for each 'producer', which contributes to our overall profit target.

The ADY that is achievable is based on the services (treatments) that a clinician provides, the charges for those services, the utilised hours/days (you could open 8-8 and seven days/week) and the demand (how many new patients; recall rates).

It is interesting to note how consistent (in production rate) that most clinicians are. All other parameters being equal, I've seen a £90k/month dentist produce that month in, month out, +/-3 per cent and the same with a £15k/month dentist. Therefore, any increase in ADY only happens with a meaningful change in one or more of the drivers of ADY.

## MEANINGFUL IMPROVEMENT

So how could a meaningful increase in ADY be achieved? Here are some ways.



- Create treatment clinic (zones) in each clinician's book. Start with one hour in the morning and one hour in the afternoon. Then only allow treatment to be scheduled into those times – NO CHECK-UPS!
- Track progress. Calculate ADYs for every clinician every month and then review with each individual. Remember, 'Don't expect, what you don't inspect'. Ask them how you can help them to achieve the target ADY.
- Buy an intra-oral camera, install it correctly and ensure all associates quickly start to use it with most patients. Then ensure they learn how to use the images they are capturing to clearly show (and then describe) to the patient where dental problems could be developing. They should be able to articulate the same level of concern as if the problems were in their mouth.
- Work faster! Remove any rate-limiting steps such as an ineffective nurse who can't quickly and accurately provide notes that hardly need any updating from the clinician.

- Invest £5,000 in a new website (this doesn't include video or photography or new uniforms for all staff). Then spend £1,500/month on SEO and PPC for the treatments you can deliver with great, evidenced outcomes.
- Employ an automated system to get Google reviews so you have at least 100 reviews and 10 new ones/month. Aim to get 15 new patients/month for each 4+ days/week dentist. Then review the treatment plans from each of those 30-minute new patient consultations, with each associate, every month and track the conversion rate – how many book in for follow-on treatment?

If your practice profitability is below where you need it to be, then it's the sales, stupid! Get the right people, with the right skills and the right equipment, then market them effectively. Easy to write but a little more complicated to implement – you will almost certainly need some help.

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.



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## MDDUS CASE STUDY:

# PERMANENT NERVE INJURY

*It is alleged that the dentist did not tell the patient about the clinical risks associated with incising an abscess...*

[ WORDS: AUBREY CRAIG ]

### DAY ONE

Mr T attends his dental surgery complaining of pain in his lower left canine tooth. The dentist – Mr R – notes a sinus draining from the apex of the tooth. A radiograph shows a periapical radiolucency and the tooth is non-responsive to cold stimulus. Mr R discusses the treatment options with the patient who decides on a course of root canal therapy. Mr R removes the non-vital pulpal tissue, irrigates the root canal, dries it and dresses it appropriately and asks the patient to make a longer appointment for root canal treatment (RCT).

### DAY 30

The treatment on LL3 is completed without complications. The patient is advised to return to the surgery if he experiences any pain or swelling.

### DAY 33

Mr T attends the surgery with pain and numbness in the LL region with swelling spreading under the tongue and difficulty swallowing. An abscess is noted at LL3 and Mr R advises that it should be incised. Mr T agrees and the dentist administers a local anaesthetic by way of an inferior nerve block, not injecting into the swelling, and proceeds to incise the abscess with a scalpel, releasing copious pus. The patient is given a prescription for an antibiotic (amoxicillin).

### DAY 40

The patient telephones the surgery to say that he is still suffering numbness in the lower left lip and some swelling. The dentist advises Mr T that paraesthesia is not uncommon and should resolve within two weeks, along with the swelling.

### ONE MONTH LATER

Mr T returns to the surgery still complaining of numbness in his lip and is seen by the dentist who says it may take up to a few months more for sensation to return to normal. The dentist makes a note in the record to consider removal of the root canal treatment if the numbness has not resolved or to discuss onward referral to an endodontic specialist or dental hospital.

More than a year later the dentist receives a letter of claim for damages in regard to his treatment of Mr T. It is alleged that the dentist did not tell the patient about the clinical risks associated with incising the abscess at LL3 and thus consent was not informed. Nor were the risks discussed for local anaesthesia involving nerve block injections. Mr T has stated that had he known of the attendant risks he would not have agreed to the procedure.

In regard to the incision it is alleged that the dentist failed to take into account the anatomical course of the mental nerve and during treatment cut it or some of its fibres. The letter also claims a breach of duty of care for failing to refer Mr T to an expert maxillofacial surgeon for drainage of the abscess and later when it became clear that the paraesthesia was not resolving.

The letter states that due to the dentist's negligent treatment the patient is now left with permanent loss of sensation, requiring referral to a dental neurological specialist for further treatment.

MDDUS advisers assess the associated case papers and commission a report from an expert in oral and maxillofacial surgery. In the expert's opinion, the nerve injury is

permanent given the period of time now passed without significant improvement.

Four theoretical causes of the injury are considered in the report. The expert rules out injury during the root canal treatment because of the position of the mental nerve relative to the apex of the canine tooth. He also believes it is unlikely that the local anaesthetic injection prior to the RCT could have led to the nerve injury. Infection could have also caused altered sensation but again the position of the nerve relative to the tooth makes this unlikely.

The expert expresses the opinion that the paraesthesia most likely resulted

from branches of the mental nerve being cut when the dentist was incising the abscess, but such a complication would not in itself be negligent.

He states that it is easy to damage these nerves as they lie just below this mucosa in the buccal sulcus. He also notes that the patient is clear in his evidence that the change in character and perception of

the sensation was quite distinct after the incision.

The crucial issue is the lack of any evidence in the patient records that the risks of the procedure were discussed.

### KEY POINTS

- Ensure that relevant risks in any procedure are discussed with patients.
- Discussions with patients in regard to consent should be recorded routinely in the notes.



Aubrey Craig is head of dental division at MDDUS



# SCOTTISH DENTAL PROFESSIONAL FOCUS

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## WE ARE DELIGHTED TO ANNOUNCE OUR NEW

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**Designed to support preparation for the new qualification: Membership in Advanced General Dental Surgery MAGDS RCS (Edin) Start Date 29th March 2019**

### Main Course Speakers:

**Dr Stuart Campbell BDS,MFDS RCS(Edin),MSC,MClInDent,MPro**  
**Dr Bruce M Strickland BDS DiplImpDent RCS (Eng)**

**The Membership in Advanced General Dental Surgery MAGDS RCS (Edin)** is the new qualification being launched by the Royal College of Surgeons (Edin). Their aim is to make this new assessment very relevant to modern dentistry and it is the only Royal College qualification available in advanced General Dental Surgery. The qualification potentially could become the accepted assessment standard for those wanting to practice within the "middle referral tier" between general practice and specialist practice. The qualification will also potentially become the new go-to qualification for post-graduate recognition in practice. Delegates on our course can choose whether or not to sit the assessment.

Dentistry is a career of amazing potential, but many dentists struggle to find a pathway to a place where they are equipped, capable and confident. Also, dentists often do not know how to unlock the potential within their own practices. Achieving this is the aim of the training program and something we have achieved for many dentists through our previous programs at Care Dental Implant Clinic.

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# A GOLDEN FUTURE

The Orthodontic Clinic in Aberdeen has earned a multi-award winning reputation. Now in a purpose-built new site, the team is determined to further enhance the standing of the practice

Dr Lisa Currie (left)



## ABOUT THE OWNERS

The practice is owned by Dr Lisa Currie and Ivin Tan.

Lisa is a consultant orthodontist. Qualifying at Dundee in 1996, she spent VT at a general practice in Edinburgh before going into hospital training and doing house jobs for several years. Lisa became a specialist orthodontist in 2003 and undertook consultant training in Birmingham Dental Hospital and Stoke-on-Trent, becoming a consultant orthodontist in 2006. She has also completed a research masters degree in sleep apnoea and is an honorary senior lecturer at Aberdeen Dental Hospital. Lisa first joined The Orthodontic Clinic in 2010.

Ivin is managing director of the practice. She is originally from Malaysia where she owned several design and printing businesses.

Lisa and Ivin bought the clinic in July 2014 and moved the business to the new site in September 2018.

## TELL US ABOUT YOUR NEW PRACTICE

The building is over four floors. The basement has a staff room, our lab and a lecture room where we do in-house tutorials and postgraduate training.

The ground floor is our clinical floor. We have the reception area and waiting room and six dental chairs. There are two enclosed private surgeries and four others which are "semi-open-plan" separated by glass panels.

We have a separate X-ray room housing a digital OPT/ceph machine, and our LDU is on this level. It houses two large, under-bench washer disinfectors.

On the first floor is our admin space. It includes a large open-plan office with space for bookkeeping and other admin duties, as well as hot-desking for nurses. There's a separate meeting room as well as Lisa and Ivin's office. The top floor is used for storage.

Our equipment includes four







autoclaves, a water purifier system and two large compressors – one regular and one back-up. We are in the process of securing an intra-oral scanner which should be with us soon.

### TELL US ABOUT YOUR STAFF AND THEIR AREAS OF SPECIALTY

Dr Lisa Currie and Dr Daria Rodolfo are the specialist orthodontists. There are two orthodontic therapists who can adjust braces (based on prescription from the clinician) and carry out fitting. The team includes a part-time GDP, eight fully qualified dental nurses and a full-time lab technician. There are two full-time receptionists and two admin staff.

### HAVE YOU NOTICED ANY CHANGES IN POPULARITY OF THE SERVICES YOU PROVIDE?

The practice offers NHS and private treatment. We provide a tooth whitening service, and Lisa's expertise in sleep apnoea means we can offer

treatment for patients with this condition or a snoring problem with bespoke anti-snoring devices. We are witnessing ever-growing demand for orthodontic services and more aesthetic treatments.

### WHAT PROMPTED YOU TO OPEN THIS PRACTICE?

The previous site was based on one floor and was a four-chair practice – we were struggling to meet the increasing demand. Even if we wanted to hire more people there was nowhere to put them. The move was to give us more space and future-proof the practice. It gives us the potential to expand our team if that's needed.

### TELL US ABOUT THE COMMUNITY YOU SERVE

In this part of the country, we are fortunate that people are quite prepared to travel for treatment. We have patients who come from far and wide – Aberdeenshire, Morayshire and Inverness-shire.



Having being established for almost 20 years, we at Sinclair Orthodontics pride ourselves on being able to provide the best quality specialised orthodontic appliances to our clients. We utilize the latest technology in digital dentistry so that we can offer our customers the services they need.

From functional and fixed appliances to gum shields, retainers and our SO Clear Aligners, our lab provides a first class service to practices and hospitals throughout Great Britain and Ireland.



**We would like to extend our best wishes to all the team at The Orthodontic Practice and we look forward to continuing our work together in the future.**

Sinclair Orthodontics Ltd, 71 Dicconson Street, Wigan, WN1 2AT  
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### DOES THE BUILDING HAVE AN INTERESTING HISTORY?

It's a lovely granite building – tall and impressive – that we believe dates from the 1800s.

Before we moved in, the building was divided into different suites occupied by oil sector companies, and it is very close to our previous location, which was also in Golden Square.

We purposely moved only a short distance. We were on the lookout for new premises for a year or two and when this building came up we thought it was perfect. We are right behind the Aberdeen Music Hall, which is a great location – it's easy to remember and there are lots of people passing by.

### HOW WAS THE PLANNING PROCESS AND SECURING FINANCE?

The planning process took a little while. Among other things, we had to apply for change of use. Ivin has a background in design as well as business and she came up with the initial ideas on how we could best shape the building to meet our needs. Meanwhile, we had an excellent architect who helped us draw up the plans. We had to apply for a business mortgage to purchase the building but apart from that everything was self-financed.

### WHAT RENOVATIONS OR STRUCTURAL CHANGES WERE NEEDED?

We did have to completely reform the inside of the building but thankfully that did not involve knocking down any load-bearing walls or any other big structural changes. Of course, we had to make the building suitable for people with a disability, and because it's a period property we had to make sure we working with the proper consents. Everything was relatively straightforward, though the process did take a little while.

### HOW LONG DID THE WHOLE PROCESS TAKE? ANY MAJOR HURDLES?

It took us around 18 months from the date of purchase to get the building up and running. There were no major hurdles along the way. We didn't hire a project manager, which meant we had to oversee the whole process while still looking after the business. We had no life outside for the 18 months, which makes it even more satisfying now that we're enjoying life in the new practice!

### WHAT SORT OF TRAINING DO YOU PROVIDE FOR STAFF?

Lisa holds a tutorial in our lecture room every Wednesday evening.

These are based around topical subjects – it may be something that's cropped up in the practice that day or could be skills-based training for the staff as required. Because Lisa lectures at the dental hospital, there is a good bank of material and clinical cases that can be dipped into.

Most of our nurses are trained to take impressions and have completed a radiography course; one has been through specialist orthodontic nurse training.

We like our staff to be CPD-focused. We take almost all the team to the British Orthodontic Conference annually, paying for attendance, travel and accommodation – we feel this is

important to keep up to date with current thinking in the specialty, and to encourage camaraderie and team building.

We have won several awards down the years, mostly underpinned by our philosophy that the team is our best asset.

### ARE THERE ANY FACILITIES SPECIFICALLY DESIGNED FOR EMPLOYEES?

It's a very comfortable environment. Among other things we have created a huge staff room that looks out onto an enclosed courtyard. Our staff can get out there for a break if needs be.



There's a separate staff toilet and shower room, everyone has their own locker and we have two car parking spaces that are rotated between staff.

### ARE THERE ANY FACILITIES SPECIFICALLY DESIGNED FOR PATIENTS?

Our aim all along was to make the surroundings plush and luxurious. We believe that's clear as soon as you walk in. We have a self-check-in system that makes the practicalities simpler for patients. The waiting area is extremely comfortable. As far as the treatment rooms are concerned we chose to have high-quality Belmont Voyager chairs with top of the range upholstery – every aspect was considered. In Lisa's surgery there is a two-seater sofa so if treating a young person, their parents can attend the session if they'd like to be on hand.

### HOW WOULD YOU DESCRIBE THE ETHOS OF THE PRACTICE?

The awards we've won have been based around being Best Team and

Best Employer. We know that a successful practice depends on having staff who are happy, highly trained, professional and inspired. When patients come to see us they can see there's a positive atmosphere and this is a great place to work. It's also unusual to have a consultant trained orthodontist like Lisa working full-time in practice. That gives us a different level of experience and exclusivity.

### WHAT WERE THE PERSONAL CHALLENGES AND HOW DID YOU OVERCOME THEM?

Since we managed the project ourselves it was a period of high pressure. However, it was enjoyable too since we knew what the end product would be. The big challenges were time management and co-ordinating the contractors. It was especially tough since we had to run the practice at the same time. The secret to success was a great deal of careful planning and a real passion for this project with the promise of a fantastic place for all our team to work.



### WHAT DO YOU ENJOY ABOUT BEING IN THE PRACTICE?

It has been a pleasure to see the renewed enthusiasm of our staff as they enjoy our new surroundings. As soon as we came in on the first day there was a great feeling of space, comfort and luxury. I think everyone is delighted with the new practice –

notably, people are getting their families to come in and have a look around. We are very proud of it.

Now that we have settled in, our immediate focus is on staff development – we are determined to make full use of this state-of-the-art practice for the benefit of our team and our patients.



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We would like to take this opportunity to wish the team at **The Orthodontic Clinic** every success for the future.



# TOP TIPS FOR PRACTICE OWNERS

Even if you are years away from considering selling your practice, it pays to take steps now to maximise the value of your business and seek professional advice on how to prepare to put it on the market

**A**s a practice owner, you will have to consider the sale of your practice at some point in the future. I have outlined some of the key things to consider in advance of a sale that will assist in maximising the value of your practice and make the process as smooth as possible.

## BOOKS AND RECORDS

It is good practice to maintain your accounting records as you would other compliance documentation in an orderly system with easy access. Storing these digitally can improve ease of access. Cloud-based accounting packages are excellent tools.

The benefit of having ready access to this information will save you time in the lead-up to the marketing of your practice and also a significant amount of time during the due diligence review of information required by a buyer.

## MAXIMISE PROFITABILITY

Have you benchmarked your practice against the market recently? Are you paying your associates above the market rate? Are you key costs in line with your competitors? It is not easy to take a step back from the day-to-day running of the practice.

The benefit of implementing the changes will not only improve your profits



Michael Edwards,  
Corporate Finance  
Senior Manager at  
Anderson Anderson  
& Brown LLP

in the short term in but, also importantly, maximise the price that you can achieve from the sale.

## DISCUSS WITH CORPORATE FINANCE ADVISORS

Even if you are years away from the event, taking early advice can help with the preparation for a sale. Some of the most active buyers in the market will require you to stay on for anything up to five years.

Discussing your plans well in advance will give you peace of mind that you are on track to deliver the best outcome for you.

This might even mean the sale of your practice sooner than you expected.

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# SELLING TO THE CORPORATES

Throwing your lot in with the devil or a sound business decision? With practices in Scotland an attractive proposition for English-based corporates, the current active market is good for sellers. With careful thought and expert advice, it may be the right move for some principals considering a sale

**O**ver the years, the prospect of selling to one of the corporates was at times seen as like selling your soul to the devil.

The view from some was that the focus of the practice would be entirely shifted, potentially to the detriment of patient care, and that the corporates would do anything to avoid paying the full price to the former principal, some of which was deferred and dependent upon various targets being met after the sale. On the latter point, that wasn't generally our experience of how things panned out, but it was the perception within the profession.

As a team, we act for a large number of principals who have decided to sell their practices, and, in the last year or so in particular, we have been struck by the growing proportion who are selling to a corporate buyer. So why is that?

Well, first of all it is clear that Scottish practices are seen as very attractive by English-based corporates, compared to England and Wales where values (and therefore prices) can be much higher. In turn, Scotland doesn't have the added complications of an NHS Dental Contract, the CQC, etc.

Couple these buyers with other corporates based in Scotland as well as private buyers and it makes for a fairly active market, which can only be good for sellers.

In turn, many sellers have decided that while they may not wish to retire fully, they want to take advantage of the currently strong goodwill values that are being secured. That fits in quite well with the corporate model of sale that often (but not always) involves the principal committing to remain with the practice for a small number of years after the sale completes.

One final reason for the increased sales to corporates is the value that has been built up in some larger practices. Some of these are beyond the financial capabilities of private buyers, particularly associates who would struggle to gather together sufficient funding (whether through borrowing or otherwise) to acquire such a practice. In these cases a corporate buyer may be the most viable option, as they tend to have much greater access to finance at the required level.

So for a principal contemplating a sale to a corporate, what are some of the key issues which you should be looking out for in the deal?



For further information please contact:  
**Michael Royden**  
Partner for  
Thorntons Solicitors  
Tel: 01382 346222  
mroyden@thorntons-law.co.uk

- Make sure that you understand and are comfortable with the terms of the price, including any part that is deferred. For example, if targets are set for the post-sale years, are they linked to you as an individual or the practice as a whole?
- Agree the detail of your continued involvement in the practice, such as your associate terms.
- What are the terms in relation to your property? If you own the surgery, will the buyer acquire it from you? Leaving it with you has potential tax implications for the future. If they are buying the premises, you should endeavour to agree a value at an early stage.
- Rather obviously, you should be sure that you are comfortable moving from being the boss to being an associate in the practice.

With careful thought and advice from those who know how the corporates tick (such as sales agents, solicitors and accountants), a sale to one of the corporates should not be seen as selling your soul to the devil, and may well be the right move for those considering retirement.

# CONSIDERING THE SALE OF YOUR PRACTICE?

With demand outstripping supply in many areas of Scotland and momentum expected to continue throughout 2019, the new year is the ideal time to start investigating the options and opportunities for your business

If you're a dental practice owner considering the next steps in your career, the new year is the opportune time to start seriously scoping out opportunities. Regardless of the type of practice you own, it is worth investigating how much your business might be worth.

The only way to guarantee that you receive the best price for your practice is by inviting parties to offer on a competitive basis. There is a growing list of buyers looking for all types of dental practices throughout Scotland, and demand is outstripping supply in many regions. On average, Christie & Co gets 10 qualified viewers for every practice marketed, and in the last year, we sold or

valued in excess of £600m worth of practices. One significant transaction at the end of 2018, the sale of Caledonian Dental Care, a 19-surgery practice in Perth, demonstrates the appetite in the market for well-run, profitable small and mid-sized groups.

Caledonian Dental Practice was first established on York Place in 1947 and acquired by Dr John Cockburn in 1989. Dr Mike San joined the practice as a co-partner in 1998, and the pair have grown the business organically for more than 20 years. In 2009, the development of a modern purpose-built practice with eight surgeries on Kinnoull Causeway brought Caledonian Dental Care to a total of 19 surgeries.



To discuss how Christie & Co might help you achieve your future plans, contact Paul Graham, Director - Medical at Christie & Co on 0131 524 3416.

The practices are now two of the busiest general dental practices in Scotland, with approximately 40,000 registered patients.

We were approached by John and Mike to value their business, position it for sale, negotiate terms and project manage the transaction. We ran a confidential marketing process to key operators in the UK dental market, and following significant interest and multiple bids being received, the business was successfully sold to Portman Dental Care. The acquisition will particularly strengthen Portman's growing portfolio in Scotland.

The dental market in Scotland continues to perform well and we expect momentum to continue throughout 2019.

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# PEACE OF MIND IN A TAXING TIME

**M**aking Tax Digital (MTD) will be at the forefront of the minds of business owners and advisers over the next few months but what is it all about?

MTD is the idea that all your business transactions will flow seamlessly to HMRC by electronic means at the press of a button. Enabling HMRC to estimate your tax liabilities throughout the year instead of many months after the end of the tax year or your business financial year.

## WHEN DOES IT START?

For the majority of dental businesses, there is no need to panic just yet. MTD is kicking off with one tax only, VAT. If you are a VAT registered business with turnover exceeding £85,000 per year then you will have to meet the requirements of MTD when submitting your first VAT return covering the period from 1 April 2019. Some businesses such as

charities, VAT groups and public sector entities have been deferred until 1 October 2019 to enable some of the complexities to be ironed out. Other taxes will not be included until 2020 at the earliest.

## WHAT ARE THE REQUIREMENTS?

MTD means you must keep your accounting records in a digital format. This means using dedicated accounting software such as Sage, Xero, Quickbooks or even an Excel spreadsheet to record transactions, just not a manual cash book. The software must be compatible with HMRC's system to transfer information electronically. If you are using a spreadsheet you may need to use 'bridging' software to make that link.

## WHAT DO I NEED TO DO NOW?

You need to ensure your existing accounting



For more information or advice, please contact  
**Louise Grant,**  
Head of EQ  
Healthcare  
(louise.grant@eqaccountants.co.uk)  
on 01382 312100.

software is compliant with MTD. If you don't currently use software then you may wish to consider doing so. Speak to your accountant who can recommend the best option for you or alternatively prepare your accounting records and make the MTD submissions for you. Do you want to spend your spare time book keeping or growing your business?

## HOW WILL IT BENEFIT ME?

From a compliance perspective there is no real benefit of MTD. However, improving technology offers us so many opportunities to work more efficiently and collaboratively and at the same time cuts down the paper trail. Accurate and up-to-date record keeping allows real time management of your business finances and tax planning. MTD may be criticised for being mandatory but it will move us forward to where we might have voluntarily chosen to go soon enough.

## Your Practice. Energised.

At EQ Healthcare, our dedicated team of specialists act for numerous healthcare practices of all shapes and sizes. We enjoy working with clients who view us as part of the team, assisting their practices to grow and develop, to realise their personal ambitions and to make a real difference.

We can offer assistance when buying or selling your practice, ensuring you have a tax efficient structure, managing your day-to-day financial controls, or providing advisory support and practical solutions to your healthcare business challenges.

For further information please contact:

Louise Grant 01382 312100 louise.grant@eqaccountants.co.uk

Anna Coff 01307 474274 anna.coff@eqaccountants.co.uk



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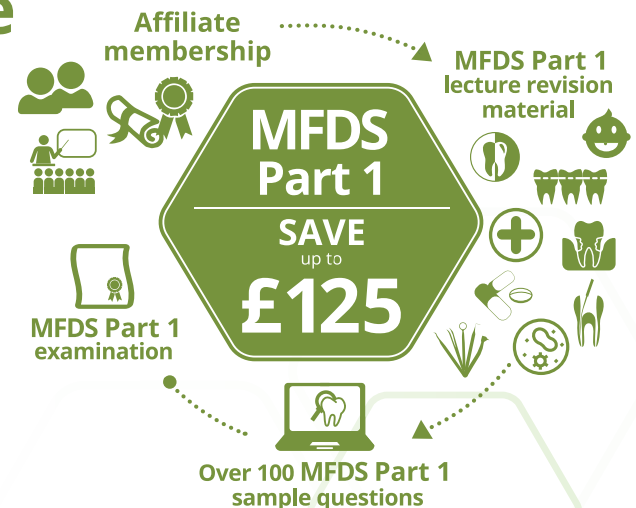
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# VALUATIONS OF DENTAL PRACTICES

Martyn Bradshaw explains the current market and what affects the values of practices

Over the last decade there has been significant growth in the dental practice market and increase in the values being paid.

## THE DEMAND

In 2006 there was a change to the Dentists Act, which allowed dental practices to trade as limited companies. This allows a corporate to retain profits (cash) in the business and therefore plan when and how to extract personal income. People looking to buy multiple practices can also use the retained profit to then fund the purchase of further practices reinforced by the significant increase in the number of smaller corporates. These smaller corporates are also competing in the market place with the larger more established practices besides the dentist who wants to buy and work in their own practice.

I estimate we are still selling about 70 per cent of practices to owner occupiers. However, each year this number is reducing, and most of the larger practices are being sought by corporates.

## WHO SHOULD YOU SELL TO?

This very much depends on your personal circumstances. The main things that may influence this are as follows:

Profitability will have the biggest impact on the types of buyers your practice will be suitable for (and what each type of buyer will be willing to pay). When valuing, we assess the practice under both associate and principal-led models. Valuations are now based on multiples of profitability and do not have any direct correlation with turnover. Once the profitability has been calculated for the two financial models, a multiple is applied to each. The reason for the multiple is that it is a return on investment for the buyer. As the profitability of an associate-led practice is generally lower than a principal-led one, a higher income multiple is used. Each model needs to be considered to see which will give the highest realistic value.

If, for example, the associate-led model gave a value of £500,000 yet the principal-led model gave a value of £400,000, then all types of buyers would generally be happy to pay the higher £500,000 for the practice. However, if working the other way whereby the principal-led model gave a higher value, a body corporate would generally not be able

to match the offer of a private buyer as they would not be able to achieve the return (income multiple) under the associate-led model.

The complexity of calculating these financial models should not be underestimated, as there will be a number of adjustments – removing all personal expenditure, items that are on/off or will not continue under the new owner and items that are ignored for the purpose of the valuation. As the profit is then multiplied, getting this wrong can easily cost thousands of pounds in values. I urge anyone seeking to sell to at least get an independent valuation (companies such as PFM Dental will provide standalone valuations even if you do not wish to use them as an agency).

Whether you wish to stay within the practice post-sale can influence the selling decision. Some of the larger corporates may request a retention (money held back from the sales proceeds) to ensure that you stay at the practice for, say, three years. There may also be targets that the outgoing principal has to commit to and achieve – which the repayment of the retention will be based on. Those looking for a clean break may have better outcomes from private buyers, who are looking to come in and replace the outgoing principal.

## MAXIMISING THE VALUE

As with selling a house, where you may be advised to give the place a lick of paint,



**Martyn Bradshaw** is a director of PFM Dental and head of sales and valuations. Martyn undertakes dental practice valuations, sales and consultancy work advising internal buy-ins and buy-outs and structures. Go to: [www.pfmdental.co.uk](http://www.pfmdental.co.uk)

there are ways to enhance the practice before marketing it. Unlike the example of the house, the main priority should be focused on the financial side of the business. An analysis of how the practice is working compared with other practices may identify some quick fixes. One of the main items that we come across is where practices employ hygienists. How are patients referred by hygienists, what pay incentive do they receive and is any charge made to the associate for the use of the hygienist? In a recent sale, we identified a cost saving of more than £40,000 by charging the associates for using the hygienists (they covered the hourly rate of the hygienist, while still receiving the fee income) and, as we were working on a multiple of five for that practice, this meant an increase in value of £200,000. The change to charging associates for using the hygienists was done within weeks (the relevant notice period was given) and we were still able to market the practice during the notice period. You do not need to worry that such changes will delay your sale.

## SUMMARY

The market is strong with a good number of buyers. This does not mean the sale of your practice demands less attention. To ensure you maximise the value, get the best terms and best choice of buyers to choose from, you should use a reputable dental practice sales agency.



# HOW HAS THE INDEPENDENT BUYER CHANGED?

Ted Johnston, Practice Consultant Scotland and Ireland of Dental Elite, considers how buyers have become more business savvy in recent years

**A**s you know, the dental practice sales and acquisitions market is constantly evolving, which can affect everything from dentists' ability to buy and sell to the practice asking price. But it's not just trends that change; so do the buyers. Independent buyers in particular have changed somewhat over the years, in that the overall knowledge of buyers on the purchasing process and market trends has improved drastically.

Whereas before dentists might have been unsure about what buying a practice entailed, it is now the case that more dentists are aware of what is involved; especially in regards to how to model a practice themselves and how aspects of the transaction – such as the valuation – theoretically work. This is due, in part, to the amount of information that is now available via different mediums and an increase in business savvy. But there's also an element of necessity, as expectations from banks are far greater than a decade ago. Buyers have to not only be able to prove that their chosen practice is viable, but that they're capable of running and growing a business. It's no longer enough to just have the clinical skills.

We've also noticed that an increasing number of dentists are less reliant on advisers; at least in regard to identifying whether a practice is a good business venture or not. This is a good thing, as it means that buyers are less likely to make bad investment decisions – not necessarily from a financial perspective, as banks don't tend to lend

against a failing or non-profitable business – but in regard to time and effort. This means that dentists are able to search more efficiently and find a more suitable practice fit for their needs.

In regard to the plans that buyers have, there's been a real resurgence over the last few years in private practice acquisitions. Of course, there's still strong interest in NHS practices and we are continuing to see dentists follow the pattern of: qualify, complete foundation training, and work for a couple of years as an associate before buying their first practice. A number of these dentists invariably go on to acquire additional practices and build what is essentially a small group, most likely with the intention of reducing their presence in the practice over the course of time.

But alongside this, there has been a notable rise in the number of dentists looking to enter into private practice, who tend to go down the route of further education after working for several years as an associate.

This has grown from the fact that because there are more and more dentists offering specialist treatments due to greater postgraduate training opportunities, not all specialists are able to feasibly offer their services as associates. These dentists are therefore seeking alternative options – that is, buying a private practice that they can work in and grow themselves.

Due to the time it takes to secure the right qualifications and financial wherewithal, these buyers tend to be a bit older. This is



For more information on Dental Elite visit [www.dentalelite.co.uk](http://www.dentalelite.co.uk), email [info@dentalelite.co.uk](mailto:info@dentalelite.co.uk) or call 01788 545 900

also the case where goodwill values are higher, though you do see younger buyers if they have the support of family money.

Where the buyer is younger or more entrepreneurial, we have seen a growing interest in buying under new structures that means they don't own 100 per cent of the practice. Not only can this be beneficial for the buyer in terms of easing some of the financial burden and providing business and clinical support, but it can also be extremely advantageous to the existing principal looking to decrease their involvement in the practice.

In light of all this, it is important to remember that trends (including those pertaining to lending) can change very quickly, meaning that the current pool of independent buyers could well be different in the future to what it is now. The market too can evolve rapidly, which can make it extremely difficult to navigate through the transaction – regardless of prior knowledge and understanding. Indeed, no matter how clued up you are, there are certain aspects of the process that are best dealt with by a specialist sales and acquisitions agency like Dental Elite. Plus, going at it alone, you can't guarantee that what you're getting is the best deal in the long-term.

As for the vendor, staying up to date with current market trends and having an awareness of what the buyer pool looks like is essential to ensuring a successful sale. Only by seeking professional help can one hope to stay ahead of the game.





# THE POWER OF 3D

Digital dentistry in focus at ADI Team Congress 2019

**“R**ight now we are truly at a crossroads for the way in which we diagnose and deliver dental implant therapy,” says David Guichet, a leading clinician from the US. “We are combining radiographic data with surface scan data to treatment plan in a 3D environment. Although guided surgery has been around for 10-15 years, the growth in ubiquitous, highly accurate, low-cost 3D design and manufacturing technologies has made the technique more predictable and accessible. The skills developed for freehand surgery remain essential for adjustments and improvement throughout the process, but digital guides streamline the dental implant workflow, ensuring a very precise surgery.”

David has fulfilled roles as programme chair for the Academy of Osseointegration, the American College of Prosthodontists and the Pacific Coast Society for Prosthodontics. He is also Past President of the Osseointegration Foundation and the Orange County Dental Society, as well as the previous Director of Continuing Professional Education for the American College of Prosthodontics. He currently runs a prosthodontic practice in Orange and Newport Beach California and is President of the Pacific Coast Society for Prosthodontics.

David will be presenting a session entitled “A Critical Look at Digital Treatment Protocols and performance of CAD/CAM” as part of the plenary programme at the ADI Team Congress 2019. Here he explains the key areas he will cover.

“First, I will talk about open versus closed CAD system architecture. Historically, manufacturers closed their systems in order to control the outcome, but open technologies enable clinicians to select all the components they perceive to be the best for each patient, affording greater interoperability and versatility.

“I will also consider how the use of intraoral scanning as a diagnostic aid is changing the way we do things on a daily basis. As of this year, my practice started scanning every new patient and we have been surprised by how this affected our awareness of each patient’s condition. By visualising their anatomy in 3D, we can combine restorative, periodontal, functional and occlusal data to ensure a comprehensive and highly accurate diagnosis. The treatment sequence is therefore enhanced as it is better aligned with the patient’s best interests.

“In addition, there is great value in sharing this data with the patient to improve their understanding and satisfaction with the outcome. When they are involved with making any necessary adjustments to their restorations through the digital design and treatment-planning phase, it becomes much easier to meet the demands of even the most aesthetically conscious patients.

“Materials contribute to this as well. One of the main advantages of digital dentistry is the patient’s ability to see and accept the result, before it is produced. I will share five-year data on zirconia reconstructions from over 2,000 minimally veneered zirconia units as part of my lecture. I will show how the results aid recommendations for the utilisation of carefully designed veneering porcelain for optimal aesthetics, while retaining favourable fit, form and tissue response.

“With modern digital design and materials, the restorations we produce today are worlds apart from those we could create in the past, making it simpler to treat aesthetically demanding patients.”

Echoing the team ethos of the ADI Team Congress 2019, David highlights the importance of establishing strong relationships between practice and laboratory:

“Digital design has enhanced the artistic performance of the laboratory – the majority



For more information or to book please visit [www.adi.org.uk/congress19](http://www.adi.org.uk/congress19)

ADI members get significantly reduced rates, join online today.

ADI Team Congress 2019  
Shaping the Future of Dental Implantology:  
Techniques – Technology – Teamwork  
2 - 4 May 2019,  
EICC, Edinburgh

of the process is completed using automated digital programmes and this allows more time for the technician to focus on the final artistic touches for more aesthetic outcomes. Plus, virtual wax-ups enable instantaneous adjustments, while in the conventional environment simple changes could require many hours of work!

“There is tremendous power in digital design. To be aware of the strengths of CAD/CAM today is to unlock the potential to treat patients in a better way. It is therefore important to establish an effective partnership with a skilled laboratory team in order to truly utilise this power.

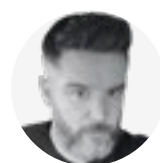
“By partnering with a skilled technical team, clinicians can share the responsibility of the digital planning, maintaining their preferred methods of working while still making use of cutting-edge technologies. There are many technicians across the profession who can now take the burden of surgical planning off the clinician, which has greatly facilitated the increased utilisation of guided surgery. In this way, clinicians can minimise their investment of time and energy, while still achieving the best possible treatment outcomes for patients.

“Effective use of digital dentistry should be consistent with sound biologic principles – it shouldn’t introduce any untested materials or processes. It takes advantage of the best dentistry has to offer and simply makes it more efficient and accessible. It provides a bright future for clinicians and patients across the world.”

David will join an array of internationally renowned speakers at the ADI Team Congress 2019, who will share their extensive knowledge and experience in a wide range of topics. For all the information you need on harnessing the power of 3D digital dentistry and much, much more, make sure you don’t miss out and book your place today!

# EXCELLENCE MOULDED FROM EXPERIENCE

From 'plaster boy' to dental laboratory owner, James Watson has built a business with a reputation for high-quality work and personal service



For more information please contact James Watson

Tel: 0141 770 6644  
jameswatson2886@gmail.com

In the last four years since James Watson established his dental lab in the north of Glasgow, he has seen the number of dentists using his services double... and now he employs three drivers to deliver dentures, chromes and orthodontics appliances across the city and beyond.

After 16 years gaining valuable experience working for various dental labs around Scotland, James decided to set up JD Watson Dental Laboratory when his former employer at Henry Hall Dental Laboratory, based in Riddrie, decided to retire. James bought over the company in November 2015 and has built up a business with a reputation for high-quality work and personal service.

James said: "This is our fourth year in business and things have been going very well. We've doubled the amount of dentists we first started with and, as business has grown, we have increased our staff from two to six now, and recently refurbished the lab. We also now employ three drivers on daily runs to service our dentists around the city but also as far west as Greenock and over

to Alloa in the east."

James worked his way up through the profession after joining a dental lab when he left school. His first job was as a 'plaster boy', making moulds, and over the past 16 years has built up experience in all aspects of dental laboratory work, both with large and small dental laboratories.

He said: "I've worked in a number of different large labs and I have found their main focus is on the high-end, high-tech dental technology for implants, and I always thought that the denture departments don't get enough attention.

"That's why I decided to focus on dentures and to give our customers' patients the very best products possible, whether private or NHS."

James believes that his team's attention to detail and focus on quality gives his dentists the extra service they are looking for to both meet their patient's needs and to work more efficiently in their clinics.

He said: "We check every dental impression that comes in, so if there is one

that is short we will not do any work on it until we get a full-depth impression. Our dentures are always fitted carefully to the models so the dentist does not waste surgery time trying to trim new dentures to their patient's mouth, and we also create 'suction chambers' on some of our dentures to aid retention in the mouth. We create an air pocket in the model before we finish the denture, which traps air between the top surface of the denture and the mouth pallet helps to hold it in place – I've not seen any of the big labs offer this technique.

James prides himself on his attention to quality, not only in training and passing on his experience to his team but also ensuring that every item that leaves his lab is top quality.

He explained: "We've got a very good quality control system here as I always give my team a brief on how each piece of work should be carried out, and I also have the final check afterwards so nothing leaves the lab until it is finished to the best standard it can be."

James is also looking to expand his services by employing a crown and bridge specialist to complement his existing offer, which includes quality prosthetics, chrome and cobalt, expert restorations and orthodontics appliances.

He added: "I think I'm a bit OCD in my work as I'm passionate about producing high-quality products. It's probably because I love sending my customers our work and receiving feedback from them that we have done a great job and that their patients are very happy with their dentures. It's a feeling of sheer satisfaction and it just makes me want to continue trying my best for my customers."



# NEW LIFE TEETH IS THE GO-TO LAB FOR FULL-ARCH TECHNICAL WORK

The implant technicians who believe in changing people's lives for the better using the ultimate in digital dentistry solutions



**N**ew Life Teeth Lab are the dental implant technicians based at Canal Point in Edinburgh, delivering high-quality, full-arch dental technical solutions and dental restorations across Scotland, the rest of the UK and Ireland.

Everything is made on site at the state-of-the-art digital dentistry lab. As a Zirkonzahn® group brand in UK & Ireland, New Life Teeth are committed to using the Prettau® Bridge and now produces the Teethforever® Bridge™, as the ultimate fixed solution. It's the longest-lasting dental bridge and the most effective way to replace missing teeth, bar none. They're proud to offer it to their clinicians.

New Life Teeth guarantee a 100 per cent bite and chewing force with a lifetime warranty.

Nothing is stronger, naturally aesthetic and more biocompatible in the mouth. New Life Teeth have made and delivered hundreds to deserving patients.

At New Life Teeth, we have a complete Zirkonzahn® milling centre to design and make onsite these beautiful Prettau® bridges. When you look at every other available option in implant dentistry, Prettau® has so many advantages. Compared to implant acrylic (plastic) over-dentures, or any hybrid acrylic (plastic) implant bridge, this is far superior.

With the new Prettau® 2 zirconia, there is excellent flexural strength and particularly high translucency.

Properties at a glance:

- Particularly highly translucent zirconia with an excellent flexural strength.
- No limitations! Especially suitable for full-arch restorations (full anatomical or reduced for ceramic veneering), but also for single crowns, inlays, veneers, bars and multi-unit bridges.
- No ceramic chipping (thanks to the fully anatomical design); no abrasion of the antagonist.
- Can be characterised individually



for each patient with Colour Liquids Prettau® 2 Aquarell, ICE Zirkon Ceramics and ICE Zirkon 3D Stains by Enrico Steger.

- Available in pre-coloured versions: monochromatic (Prettau® 2 Coloured) or polychromatic with natural colour transition (Prettau 2 Dispersive).

Rob Leggett, founder of Scottish Denture Clinic and co-founder of

New Life Teeth, said: "Our philosophy is simple. We believe in changing people's lives for the better. Our service to you is underpinned by three key elements: leading-edge technology, professional expertise and unrivalled skill."

For more information call the team on 0131 564 1822 or visit [www.newlifeteethlab.co.uk/](http://www.newlifeteethlab.co.uk/)



SCOTTISH DENTAL

# IMPLANT GUIDE FOR 2019

If you would like to showcase  
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Mobile: 07894690000



**COLIN** Hart  
colin.hart@southernimplants.co.uk  
Mobile: 07771435110



**SOUTHERNIMPLANTS**

Expanding Proven Concepts

## INNOVATIVE SOLUTIONS FOR CHALLENGING CASES

At Southern Implants, we have been  
providing innovative solutions to dental  
professionals since 1987.

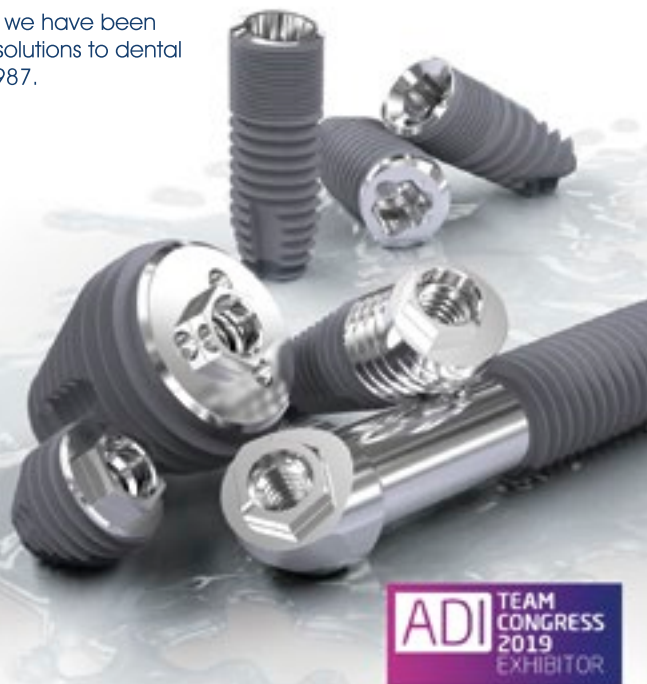
### CO-AXIS implants



### MAX implants



### ZYGOMATIC implants



# CHOOSING YOUR IMPLANT SYSTEM – IS IT ALL ABOUT THE SUPPORT?

Established in 2008, Implantium UK is the distributor of innovative implant products and continues to be disruptive.

Implantium is proud to be the UK distributor for Dentium, a future-leading dental implant company. Dentium is a Korean implant system that was listed as number 1 in the domestic dental field by the Korea Composite Stock Price Index in 2017. Renowned for its research and development leading to long-term stability, Dentium is not content to settle for its present global reach and is now aiming to enter the global top 5 by 2020.

When Implantium UK was launched more than 10 years ago, it upset the UK dental market by introducing a comparable quality implant product costing 40 per cent less than the leading Swiss implants at the time. Since then the dental community has become accustomed to lower cost implant systems with the big names introducing and developing lower cost brands. One only has to look outside the dental field at the supermarket business to see the changes with the big rise in Aldi and Lidl.

The DASK kit from Dentium was seen as a game changer when Implantium launched it in the UK in 2009, bringing a new way to facilitate sinus lifts, speeding up the process and improving safety. DASK continues to be a leader in this area. Implantium's sister company Dentale Training offers hands-on courses to learn the technique.

Emma Buglass, Marketing Director, outlines how Implantium has challenged the traditional way of selling implants by doing away with traditional reps and replacing their role with a combination of iEcoreps, clinical advisors and online meetings.

"We can offer the opportunity to see a variety of our products in the form of an iEcoRep. The iEcoRep is a portable kit containing a tailored sample of our products that is delivered to you for your convenience. A collection is then arranged a

number of days later at a suitable time. This gives you the opportunity to familiarise yourself with some of our main products at your leisure, completely free of charge.

"The iEcoReps are equipped to facilitate video calling so if you wish to speak to one of our experts, our experienced team is happy to answer any questions. We have recently released our downloadable IPDF catalogues, which allow you to listen to more information about the products.

"Our clinical advisors are trained implant nurses with many years of experience who can offer support. We have worked incredibly hard to create a knowledgeable team that helps our customers. A clinical advisor is usually available to talk on the phone during office hours, saving our customers time and effort when selecting products. Our lab customers find this particularly beneficial."

Implantium is proud to receive testimonials such as the one in the panel on the right.

## KEEPING ABREAST OF NEW TECHNOLOGIES

Three years ago Implantium was delighted to be invited to distribute Versah products. Versah is a US company that has developed and manufactured the Densah burs for osseodensification.

Many key implant dentists have embraced this new technology, and excellent scientific results have been published worldwide. Implantium is focusing its corporate forum at the ADI in Edinburgh in May on DASK and osseodensification and is pleased to welcome Snjezana Pohl, a DentalXP expert and a lecturer at



## 'Implantium is brilliant!'

"AS a private laboratory specialising in implants, we have seen nearly all of the implant systems available on the market and have had to plan each individual case based on each system's components. Sadly there are many systems that do not have the components needed to provide a suitable treatment plan and thus the cases are compromised from the start!

"Implantium is one we highly recommend for three main reasons:

- 1) It has a wide range of solutions and components and as yet all our cases have had the optimum outcome.
- 2) The quality of the parts is equal to any of the most expensive systems on the market
- 3) To us, equally as important as the above is the office team – for ordering, their technical support and product knowledge is second to none!

This makes ordering parts simple and gives us confidence that what we need is what we get.

"Keep up the good work Implantium, you are making our lives easier.

**Geo Morgan, DTG RDT, Passion Dental Design Studio**

**IMPLANTIUM**

worldwide dental meetings. An active lecturer in the fields of implantology and periodontology, she underlines the importance of minimally invasive techniques, especially in a comprehensive treatment methodologies based upon preservation of tissues such as partial extraction therapies, autogenous tissue use, osseodensification and others.

In the fast-moving digital implant world, Dentium offers a range of digital solutions that Implantium has embraced and added to. The digital solutions include intraoral scanners. Following a collaboration between Dentium and Medit. The Medit IOS scanner represents excellent quality and great value for capital investment. Dentium has developed ingenious intraoral scan bodies for digital implant restoration provision that also serve as a healing abutment. Along with its sister companies Dentale and ImplantGuidePrint, they are able to provide training and surgical guides.

Emma describes what she thinks are the key components to their business strategy moving into 2019. "Established and still run by the founding dentists, we strive to offer our customers a personal service and like to think that we listen and act on their requests. While increasing in size it is imperative that we maintain the personal touch without pestering our customers. Social media and digital developments have rapidly increased global communication which means that our customers can interact easily with us and other users of the products that we distribute. Anything that improves communication is a good thing as it is important we retain our grass roots approach and customer focus. We will be exhibiting at the ADI congress in May this year in Edinburgh under the title *Made you look, made you stare – Implantium is everywhere.*

"A bold statement with a twist. Come and visit us at our stand to find out more."

# CLIFTON THRIVING UNDER NEW OWNERSHIP

Clinic going from strength to strength with growing team of experienced professionals and expanded services

**W**hen Allan Pirie made the decision to begin winding down a little, he was faced with a

number of options and decisions. Having spent the last 17 years building a highly respected implant referral clinic, Allan knew finding a successor was going to be a difficult decision to make, especially when he was not quite ready to hang up his high speed just yet!

Clifton Dental & Implant Clinic's acquisition in March 2018 by the Cheltenham-based Portman Dental Care family meant that Allan was able to remain within the clinic as clinical lead, while ensuring the services that the clinic had provided to many referring colleagues over the past 17 years would not only remain in place, but would continue to thrive and further develop the foundations that Allan had put in place.

## BUILDING A SUCCESSFUL CLINIC

While expanding the range of services available over a number of years, Allan's reputation has allowed him the luxury of selecting experienced clinicians with a similar passion for providing exceptional quality patient care, building a strong team of skilled clinicians at Clifton Dental.

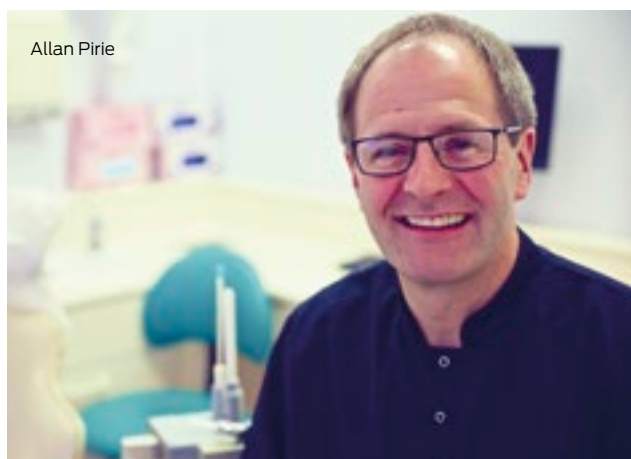
Ross Henderson joined the team in 2010, while completing his master's degree in endodontics introducing a private endodontic referral service.

Over the past five years the implant team has continued to grow with the welcomed addition of respected local dentist Mark Sorrentino and Edinburgh-based dentist Helen Young, both of whom bring a huge wealth of experience in implant and restorative dentistry.

Mark is a well-known name in dentistry, having previously built his own successful practice in Ayrshire. Since selling this practice he has maintained strong links with his successors, providing both business and clinical mentoring.

2019 sees Helen celebrate a

Allan Pirie



remarkable 40 years in dentistry! During this time Helen has seen almost all aspects of dentistry, including spells in both general dentistry and maxillofacial units. Helen has lived and worked in Australia and perhaps one of her proudest achievements remains providing both clinical training and dental treatment within aid projects in Tanzania, something which Helen continues to do today.

Allan's passion for learning and continued development has made him a sought after mentor among local dentists undertaking post graduate implant training, as well as developing a popular Refer & Restore programme.

One of Allan's most recent mentees, Dr Catriona Easton, has since joined the clinical team at Clifton Dental & Implant Clinic. Catriona graduated from Glasgow University in 2007 and completed her VT in Anstruther in Fife. She went on to spend the next eight years splitting her time between dental practices and oral and maxillofacial surgery units in Glasgow, Livingston and Inverness. Today, Catriona is undertaking a Diploma in Implant Dentistry at the Royal College of Surgeons, London, in her spare time.

Catriona brings considerable experience in both sedation and oral

surgery and is looking forward to developing a surgical referral service at Clifton Dental. Her expertise adds oral surgery and sedation to the implant, endodontic, CT, periodontic and cosmetic referral services offered at Clifton Dental & Implant Clinic.

Forging strong partnerships with referring colleagues has played a central role in the success of Clifton Dental & Implant Clinic. They are very conscious of the vulnerabilities often felt by dentists when referring a patient and are committed to building a trusted and collaborative referral service for referring dentists, with a first-class experience for patients. This commitment has seen the clinic build a trusted referral base of more than 100 practices across the country.

Their clinicians in both implant and endodontic fields have always had an open-door policy, where they are delighted to welcome referring dentists and their teams into our surgeries to gain an insight into their patients' experience.

This enthusiasm for involving referring colleagues in implant dentistry has led to the development of Clifton Dental's popular Refer & Restore programme, where they work closely with referring colleagues, providing everything from team CPD lunches to restorative training modules, where the clinicians learn to

complete the implant restorative phase in their practice.

## REFER & RESTORE TRAINING PROGRAM

In order to address their referring dentists' desire to be more involved in their patients' dental implant treatments, Clifton Dental have extended their 'Relax' implant restoration program, and in conjunction with Dentsply Sirona Implants, have developed it into a three-unit Refer & Restore modular training programme. This has proved hugely popular with many practices joining the first two cycles, learning to develop not only their clinical skills but the entire team's approach to implant dentistry.

## FUTURE OF CLIFTON

The future for Clifton Dental & Implant Clinic is looking great. Portman Dental Care is fully supportive of all that Allan has built and continues to support the practice to thrive under its new ownership. One of the benefits of being part of a group is the administrative support, ensuring dentists have more time to spend doing the dentistry they love, while providing support to develop skills, training and referral programmes further. And as Portman guarantees their practices clinical freedom, the level of service and technology you have come to know and expect from Clifton Dental & Implant Clinic won't be changing.

Allan Pirie told us "We are looking forward to the upcoming year and extend a warm welcome to the practice for any local dentists wanting to find out more about our referral or training programmes."

For more information on the Clifton Dental & Implant Clinic visit [www.cliftondentalclinic.co.uk](http://www.cliftondentalclinic.co.uk) or call 0141 353 3020. For more information on Portman Dental Care visit [www.portmandentalcare.com](http://www.portmandentalcare.com)



## &gt; NOBEL BIOCARE



## KEEP THEIR MOUTHS METAL FREE

With alternatives now available, more and more patients are looking to discover the benefits of non-metal implants.

Keep their mouths metal free and achieve natural looking aesthetics with the new NobelPearl™ from Nobel Biocare.

The only two-piece ceramic implant on the market, NobelPearl features a high-performance, metal-free screw that ensures a strong ceramic-to-ceramic connection.

Furthermore, the implant features a hydrophilic, sandblasted ZERAFIL® surface which has been proven to osseointegrate effectively and demonstrates a low plaque affinity, helping you to deliver predictable, long-lasting results.

Go metal free and discover the innovative NobelPearl by contacting Nobel Biocare today.

For more information, contact Nobel Biocare on 0208 756 3300, or visit [www.nobelbiocare.com/pearl](http://www.nobelbiocare.com/pearl)

## &gt; CARESTREAM

## CAPTURE EVERY DETAIL WITH THE NEW CS 9600

Implementing cutting-edge technology to ensure fantastic results, the new CS 9600 CBCT machine from Carestream Dental is carving its way into the future with a series of impressive features.

Using CS Face Scan, the device can capture fully realistic 3D facial images and automatically superimpose the surface scan with CBCT images and 3D models – ideal for oral and maxillofacial surgery.

The device also uses Live Patient Positioning Assistant – cameras that send real-time images to the professional's touch-screen to aid easy and exact positioning.

Discover more features by contacting the team today.



For more information, contact Carestream Dental on 0800 169 9692 or visit [www.carestreamdental.co.uk](http://www.carestreamdental.co.uk). For the latest news and updates, follow us on Twitter @CarestreamDentl and Facebook

## &gt; DMG UK



## ICON SEE THE LINDA GREENWALL VIDEO ON DMG'S UK WEBSITE

Icon is DMG UK's revolutionary treatment for incipient caries and carious white spot lesions ... without drilling!

To find out how Icon can enhance your practice and introduce a new revenue stream, watch the Linda Greenwall video on DMG UK's website [uk.dmg-dental.com](http://uk.dmg-dental.com). Follow the link [uk.dmg-dental.com/products/caries-infiltration/icon/product/caries-infiltrant-smooth-surface/](http://uk.dmg-dental.com/products/caries-infiltration/icon/product/caries-infiltrant-smooth-surface/)

Icon is an innovative caries infiltration therapy. It represents a breakthrough in micro-invasive technology that reinforces and stabilises demineralised enamel without the need for drilling or sacrificing healthy tooth structure. The first product to bridge the gap between prevention (fluoride therapy) and caries restoration, Icon's micro-invasive infiltration technology can be used to treat smooth surface and proximal carious lesions up to the first third of dentine. In just one visit Icon can arrest the progression of early enamel lesions and remove carious white spot lesions.

Icon offers a simple alternative to the "wait and see" approach, enabling dentists to offer an immediate treatment without unnecessary loss of healthy tooth structure.

For further information contact your local dental dealer or DMG Dental Products (UK) Ltd on 01656 789401, email [info@dmg-dental.co.uk](mailto:info@dmg-dental.co.uk) or visit [www.dmg-dental.com](http://www.dmg-dental.com)

## &gt; DENTASKY

SEE DENTISTRY  
IN A DIFFERENT  
LIGHT

Precision is key when it comes to excavating caries; however, improvements in restorative materials mean that it's often difficult to see the margin between healthy tooth structure and common restorative materials. The Fluoresce HD Dual Wavelength Coupling makes caries detection and removal easier as well as minimising the risk of removing healthy tooth structure. How? During caries removal the UV light causes porphyrins inside caries to fluoresce orange/red (and healthy tooth light green). The UV light also causes restorative materials such as resins, cements etc. to appear a different colour. Since you can see everything as you're working, caries removal comes 'paint by numbers' simple – only remove what needs to be removed.

This 2-in-1 handpiece coupling is compatible with Kavo MULTIflex turbines. You also get a device that detects caries. The user needs to wear a yellow filter to see the caries. These are available as yellow tint glasses or as a yellow tint loupe insert.

Fluoresce HD is distributed exclusively through Dental Sky.

For more information visit  
[www.dentalsky.com](http://www.dentalsky.com).

## &gt; DENTASKY

DENTAL SKY  
HAVE YOU  
(COLOURFULLY)  
COVERED!

Whatever type of dental examination glove you are looking for, Dental Sky has the solution. The Medibase range of gloves includes the popular Powder Free Nitrile Gloves that allow great tactile sensitivity with a textured surface to ensure excellent grip. Being powder and latex-free these gloves appeal to those with allergies or those who wear gloves for long periods.

All the Nitrile gloves within the Medibase range are high strength, tear resistant, CE marked and conform to European standards EN 455-1 & EN455-2. Available in a wide range of sizes, Medibase gloves are highly elastic making them extremely comfortable to wear. And because Dental Sky like to bring a little more colour into everyone's lives they've now extended their range of Nitrile Gloves with several new vibrant colours: Medibase Nitrile Gloves are now available in Blue, White, Green, Purple or Pink.



To learn more or see the latest offers please visit  
[www.dentalsky.com/disposables/nitrile-gloves.html](http://www.dentalsky.com/disposables/nitrile-gloves.html)

## &gt; DENTASKY

COSTS LESS,  
LASTS LONGER

It's rare in life that you can get more for less, but this is not the case with Orabloc 4% Articaine. Dental Sky is delighted to have partnered with Pierrel to bring you Orabloc, the only aseptically manufactured local anaesthetic available in the UK. Pierrel have been manufacturing dental anaesthesia for over 40 years, with Orabloc widely distributed in the US, Canada and Europe.

So, how does it differ? As less degradation of epinephrine occurs during production, only 10% overage of epinephrine is experienced (compared to 15% in other anaesthetics). Orabloc has an impressive shelf life – 24 months at room temperature – again significantly preferable to the shorter expiration dates of other anaesthetics. Efficiency is ensured, with rapid onset of anaesthesia from 1-3 minutes. The pH of the solution (which makes the injection less painful) remain stable through the lifetime of the product. It can be used in adults and children over four years of age, who require extended analgesic time, for more complex treatments. The addition of a vasoconstrictor also decreases bleeding during surgery as well as increasing the effect of the local anaesthetic.

For more information visit  
[www.dentalsky.com/pierrel](http://www.dentalsky.com/pierrel)

## &gt; DENTASKY

## WHY SKY?

We're all comforted by genuine customer feedback, which is why Dental Sky decided to introduce Trustpilot on its website. Arguably behind every review is a valid customer experience; positive ones give reassurance that you are meeting customer expectations, as well as giving confidence to other customers that your business is built on honesty and transparency. Negative reviews can also be beneficial, as they provide an opportunity to review, assess and if necessary, take steps to improve the overall customer experience.

Trustpilot makes it easy for customers to leave reviews and Dental Sky is delighted with its current score of 9.5 out of 10. Joe Earl, Marketing Manager at Dental Sky, commented: "We didn't want to rely on a 'gut feel' for how we were doing. Using Trustpilot allows us to solve issues before they become problems. It also tells us exactly what it is that our customers like about us. Ease of use of our website was a key motive, alongside good/transparent pricing and next day delivery with order tracking."

Work can be complicated, but one thing that shouldn't be is ordering your sundries.



If you want to simplify the process, then visit  
[www.dentalsky.com](http://www.dentalsky.com).

## &gt; JOHNSTON &amp; JOHNSTON

## INTRODUCING LISTERINE® GO! TABS – FOR LONG-LASTING FRESH BREATH ON THE GO



Johnson & Johnson is delighted to unveil the details of its revolutionary new LISTERINE® Go! Tabs to dental health care professionals, ahead of the launch to consumers in the UK.

Chewable LISTERINE® Go! Tabs offer an

innovative way to get the whole mouth feeling clean and fresh anytime, anywhere, as a handy addition to – not a replacement for – twice-daily mechanical cleaning at home.

Ninety per cent of halitosis is a result of the production of volatile sulphur compounds (VSCs) by oral bacteria.

Tackling this problem, when chewed, for example after a meal, at social gatherings, before a meeting or after a coffee, LISTERINE® Go! Tabs transform from solid to liquid in seconds, neutralising odours for long-lasting fresh breath.

Johnson & Johnson's oral care portfolio includes the familiar brand of mouthwash, LISTERINE®, with variants suitable for daily use as an integral adjunct to mechanical cleaning to deliver an optimised daily regimen. In addition, the LISTERINE® Advanced Defence range is available to help dental professionals deliver advanced treatment outcomes for patients.

Johnson & Johnson, the maker of LISTERINE®, is committed to supporting dental health care professionals in their efforts to improve patients' oral health.

For further information, visit [www.listerineprofessional.co.uk](http://www.listerineprofessional.co.uk).

## &gt; GC UK LIMITED



## NEW TEMPSMART DC GUARANTEES A SMOOTH RIDE TO YOUR FINAL RESTORATION

As one of the world's most innovative dental companies, GC's expertise and experience in temporary materials has been proven through time with the very successful Unifast range.

GC is now proud to present a real evolution in temporary crown and bridge materials, one that will make a real difference. Tempsmart DC, a dual cure temporary material, offers a new technology which is plasticizer free, which makes the polymerized surface hard, non-sticky and smooth with virtually no inhibition layer – perfect for fast polishing!

Featuring a comfortable working time, the final light-cure reduces the setting time while achieving optimal hardness. In just three minutes you can have naturally beautiful and strong provisionals.

Delivered in 1:1 ratio cartridges and the automix syringe, Tempsmart DC contains a high-density polymer network which provides long polymer chains, making it the first in class for fracture toughness and resulting in temporaries that actually last long enough, be it single units or long span bridges.

Tempsmart DC's ultra-fine fillers give it superior polishability for a gloss that lasts over time.

Tempsmart DC is available in six shades, all with natural fluorescence for beautiful results.

For more information please contact GC UK Ltd on 01908 218999, e-mail [info@gcukltd.co.uk](mailto:info@gcukltd.co.uk) or visit [www.gcukltd.co.uk](http://www.gcukltd.co.uk)

## &gt; DURR DENTAL

## PERFECT PROPHYLAXIS

Lunos®, from Durr Dental, is a premium prophylaxis brand covering a range of products that offer unique advantages over existing products.

One example of this is the MyLunos powder jet handpiece. Its unique exchangeable chamber principle means the powder container can be replaced quickly and easily, avoiding the inconvenience of having to refill in the middle of treatment. Furthermore, surgeries can prepare enough powder containers for the whole day. The tip can be rotated 360 degrees, which makes it easy for the operator to use as they can access all areas of the oral cavity. All components are autoclavable and the unit fits all standard turbine couplings.

MyLunos works with various prophylaxis powders. The Gentle Clean variant of Lunos® contains innovative new abrasive agents based on the non-carcinogenic disaccharide trehalose for gentle cleaning in the supragingival area and is available in three different flavours. Alternatively, there's Lunos® prophylaxis powder Perio Combi for supragingival and subgingival treatments. The excellent water solubility of this powder enables safe, virtually residue-free dissolution in the periodontal pocket and suction system. Thanks to this, patients no longer experience the unpleasant grittiness typically associated with this type of product and it doesn't clog up the suction unit of amalgam separator!

Also, included in the Lunos range are polishing pastes, an alcohol-free rinse solution, a fluoride varnish, fluoride gel, and fissure sealant.





## &gt; COLTENE

## SLIM, POWERFUL, CORDLESS

The Coltolux® LED from COLTENE combines a slim curing probe with high output to deliver a powerful, fast and effective cure with every use.

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The innovative design even includes heat-sink technology to reduce the amount of heat emission and eliminate the need for active cooling, helping to reduce chair time and improve the patient's overall treatment experience simultaneously. It's an ideal tool for any dentist offering restorative treatment.

To order, simply get in touch with COLTENE's knowledgeable and professional sales team today; the power of the Coltolux® LED awaits.



To find out more visit [www.coltene.com](http://www.coltene.com), email [info.uk@coltene.com](mailto:info.uk@coltene.com) or call 01444 235486

## &gt; ADI



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For more information or to book please visit [www.adi.org.uk/congress19](http://www.adi.org.uk/congress19) ADI members can attend at significantly reduced rates, join online today.

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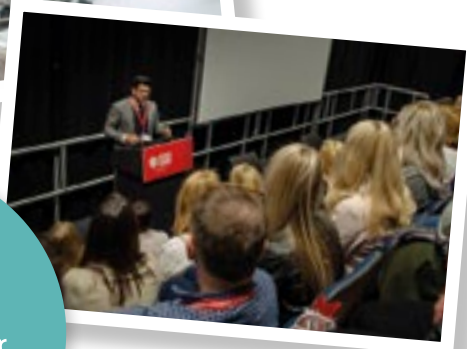
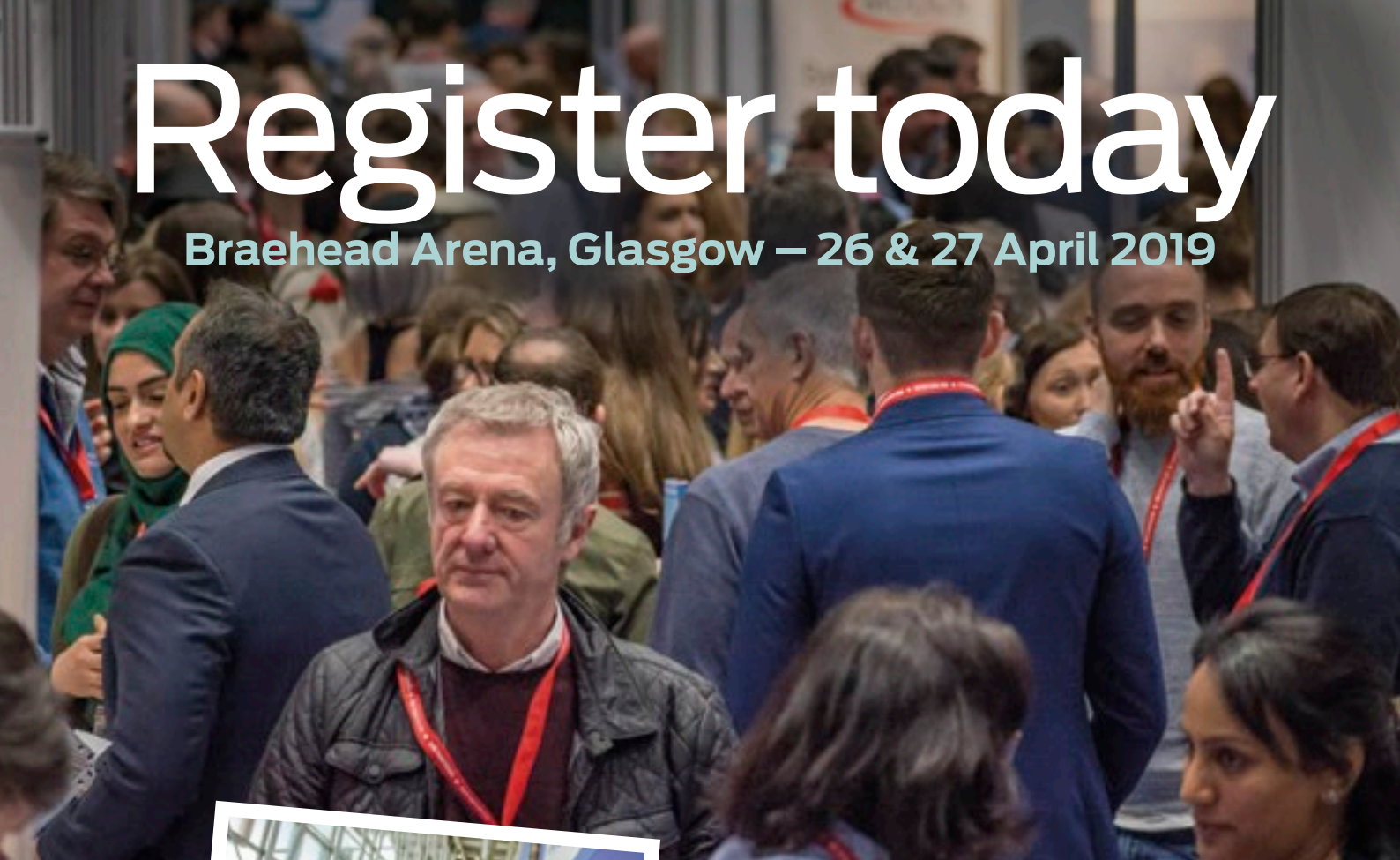
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