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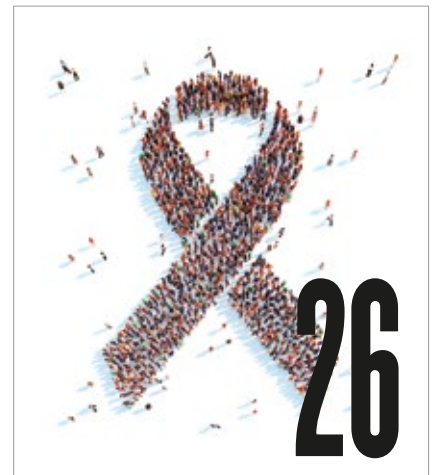
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Void at the top

Dentistry's ability to deliver and sustain effective patient care demands strong leadership

In March, on the eve of International Women's Day, I attended the first Royal College of Physicians and Surgeons of Glasgow President's Lecture since the installation of their new President, Dr Jackie Taylor. It was delivered by the Chair of the GMC, Dame Clare Marx, and the subject was *Clinical Leaders – your patients need you*. Following the lecture, I had the absolute privilege to join 50 other specially-invited female guests at a dinner to celebrate the role and achievements of women in healthcare, with a continuing focus on leadership.

So why am I mentioning this? In putting this edition together, with its focus on dentistry from the patient perspective, what struck me more than anything was the importance that good leadership has in the patient experience. Whatever the clinical pathway, and whatever the eventual outcome for the patient, good leadership ensures strong, efficient, effective teams who are able to focus on using their skills and expertise to the benefit of their patients, providing excellent and safe care. Poor leadership, and unfortunately there is much of it out there, negatively impacts teams and patients, as well as the healthcare services, organisations and practices in which it happens.

It's easy say you are a leader by dint of your role and responsibilities, but being called upon to lead, and being a good leader are two very different things. Leadership is more than a job description, it is the behaviours you exhibit; the way you communicate – the very fact that you do communicate; the way you make your colleagues act and feel, and how you support them to develop, whether you can bring out the very best in them; the confidence and trust you inspire in your patients and the relationships you build with them. Good leaders display, among other things, integrity and honesty; creativity and innovation; commitment and passion; and they inspire and motivate their colleagues.

It is important to remember, therefore, that this means anyone can behave as a leader, whatever their role. It is very true that in a clinical environment there needs to be a clear chain of leadership, a person in charge who is responsible for the situation and the team. They might be a GDP, a

DGP, a surgeon, or someone else entirely, but they are usually where the buck stops in that particular clinical situation. But one of the qualities of a good leader is that they are not afraid to be challenged.

No one is infallible, and team members must feel able to show their own leadership, to challenge, to put forward ideas, and to step up and take responsibility, when necessary and appropriate. After all, there is significant evidence to show that teams who have a dictatorial, micro-managing leader who

exhibits no compassion for or faith in their teams, who will not support their team members to grow, develop and take on responsibility, and who might exhibit bullying and undermining behaviour – in the very worst cases – will be dysfunctional, inefficient and ineffective. This is where mistakes can creep in, and where patient safety and care can be compromised.

One of the other things that became evident while putting this edition together is that there is increasing concern about a void in leadership for dentistry in Scotland, and what impact that might have. It is now some nine months since Margie Taylor announced her retirement from the post of CDO, and three months since she actually retired. Despite all this time, there is still no sign of a process to replace her permanently. It is true that there is an interim CDO in Tom Ferris, but, unfortunately, an interim post does not bring the stability and permanency that is required for such an important role. If this were not bad enough, it is now clear that dentistry as a key healthcare profession has been downgraded from being a Cabinet Secretary remit, to a ministerial one, with Jeane Freeman having divested herself of it, passing it down to Joe Fitzpatrick, Minister for Public Health, Sport and Wellbeing. This is concerning as it implies that dentistry is not seen as being as important as medicine by the Scottish Government. But this risks an alarming vicious circle. If dentistry is not seen as important enough for the Cabinet Secretary portfolio, then what is going to drive the recruitment of a new CDO? And without a permanent CDO, who is going to raise the profile and status of dentistry with government? Who is going to put the case of dentistry forward? Who is going to support and deliver the investment and change that the professions needs? After all, isn't true that nothing can live in a void?

Perhaps, therefore, this is where everyone working in dentistry needs to become a leader? Perhaps it is the responsibility of all dental professionals to speak to politicians, the public and colleagues in other areas of healthcare and demonstrate the critical importance of oral health and the dental profession as a whole. It's a big ask. Particularly in the context of increasing stress, anxiety and disillusionment, but surely true leaders can lead and inspire however bleak the situation appears. They can find the good and magnify it, they can see the opportunities and follow them through, whether this is on a micro level, or on big public platforms. Perhaps.

So that is why I mentioned the RCPSG President's lecture on leadership. But why was it relevant that it particularly celebrated women leaders. Well, that's simple. There's a lot of evidence to suggest that women are better natural leaders than men, and that having them at the top of organisations changes culture and drives positive organisational change. I'll just leave that there.



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Patience rewarded

There are many stressful and rewarding things in dentistry. Should that be the other way round? Should we maximise the positive and minimise the negative? What's the best thing in dentistry? What's the hardest thing in dentistry? Are these rhetorical questions? Is this just a riddle?

So why am I getting all cryptic? Why don't I answer a question? Well, I'm in a bit of conundrum. How do I address the single most infuriatingly complicated thing in dentistry: patients?

Where the hell do you start with patients? Well, I suppose we'll pretend this is a new patient examination. This is going to be full of questions. That's how you find out what people want. Isn't it? Well, no. People don't tell you what they want. They hide things, they tell half truths, they say what they want you to hear and what they think you want to hear. More riddles?

People are complicated. They also have complex needs and desires. They are often anxious about dealing with super-smart people in a position of power. Not only that; they probably don't like being at the dentist and think they have something wrong which is going to require a horrible procedure to fix it. A psychological nightmare. Yet this is what we deal with day in day out. Additionally, many of our patients can have deep-seated psychological issues, some will affect our care and some won't.

Are there some rules we can follow which might minimise our risks and maximise the rapport we develop? The one I was taught was treat everyone like they are your family. I hate treating my family. I find it very difficult to be objective. I don't want to hurt them, but I don't want my lack of ability to do the right thing to affect their care. That's a horrible situation to be in. So I find it easier to avoid that. But that's professionalism, isn't it?

So let's start again. New patient examination. Introduce yourself, be pleasant, likeable. Ask how they are? Ask what you can do for them? Listen and reflect the listening. I'm pretty sure that's what we're taught nowadays. In short, show you care. Show you want to care. That's a very good start.

Obviously the next stage is to perform some treatment to the best of your ability and communicate a reasonable level of expectation. That is probably the simplest, most complex sentence in dentistry. This is the key to good patient management. Do something which the patient expects to happen. They expect it because you told them what to expect. The outcome is what

they expect or better because you have managed their expectation commensurate with the patient's desires, budget and reasonable clinical possibilities. This is simple enough to write but takes a lifetime of experience to deliver well. It is also a reasonable set of statements which can relate to all facets of healthcare.

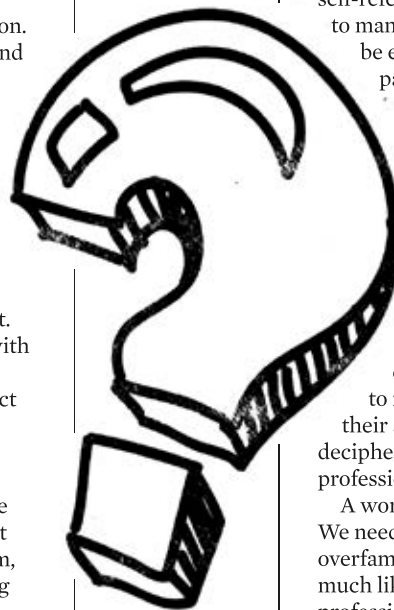
Here's the point where dentistry differs. Especially general practice. We have a much more frequent yet invasive relationship with our patients. GPs don't see all their patients every six months. Neither do pharmacists or opticians. Certainly not hospital doctors, specialists or self-referral clinics. Admittedly, some people just self-refer to us when they're in pain. They can be hard to manage. Some refer for aesthetic reasons. They can be even harder to manage. But the majority of our patients, return time and again. For treatment which can be difficult, expensive and sometimes painful. Yet they return.

How do we manage that? Charisma. Care. Understanding. Rapport. We need to create a long-term relationship built around sound clinical principles and reliability. Trust. It probably doesn't matter the combination of these skills we develop or use because every single patient will differ subtly in their expectation. So we have to trust our own emotional intelligence. We have to learn to read people. Ask the right questions and assess their answers. Respond to the body language and decipher it. But also to deliver a consistent persona and professional demeanour.

A word of caution. Back to the treat-like-family thing. We need to strike a balance between rapport, trust and overfamiliarity. If we allow our patients to become too much like friends or family, can we really maintain a professional relationship? A level of professionalism which does not blind us to clinical need.

Equally, do not be so detached that you don't get to know the patient. This is more of a clinical caution. Be wary of patients who attend desiring large amounts of treatment. If you don't know them, clinically, then you may get caught out by unexpected clinical expectations, or a lack of possibility for the desired outcome.

So do we have some rules? Get to know your patient, clinically and personally. It will help to build the relationship and make better decisions. The better you know the patient and their family, the better chance you have of accurately assessing their expectations and desires. Remain professional throughout. Listen to the patient. Listen carefully. Don't berate yourself when things go wrong. It happens very infrequently. Finally, enjoy the relationships we develop with our patients. It is a privilege to be involved and trusted to care for people. It's the best thing in dentistry.



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UK is bottom of the class

An international survey shows that UK schools are ranked last in promoting good oral health among children and families

A SURVEY undertaken on behalf of the World Dental Federation (FDI)* has shown that UK schools rank last in promoting good oral health.

When asked if their child's school provided lessons on the importance of good oral care, only 29 per cent of parents from the UK said this was the case, which was dramatically lower than the results from 12 other countries.

The findings came as another global study showed how poor oral health can have a telling effect on children far beyond medical problems.

The FDI report put the UK at the bottom of the list behind the US (53 per cent), Australia (54 per cent), Germany (69 per cent), China (77 per cent), Saudi Arabia (81 per cent), Poland (84 per cent), Morocco and Algeria (86 per cent), Indonesia (87 per cent), Brazil and India (91 per cent), and Mexico (93 per cent).

Meanwhile, 49 per cent of parents

from the UK also 'didn't know' how often their child's school gave lessons on good oral care.

The result prompted the British Dental Association (BDA) to renew its call on the Westminster government to mirror action

“

**THE MISSING PIECES ARE
OUTREACH, EDUCATION AND
SUPPORT BUT SADLY TRIED-AND-
TESTED APPROACHES ARE NOT
BENEFITING ALL OUR CHILDREN”**

MICK ARMSTRONG, BDA CHAIR

that has already been taken in Scotland and Wales.

BDA Chair Mick Armstrong said: “There is no reason why the UK should be at the bottom of the class for oral health education. The missing pieces are outreach, education and support, but sadly tried-and-tested approaches are not benefiting all our children.

“Scotland and Wales have pioneered programmes in nurseries and primary schools that have been adopted worldwide, and kids across England deserve the same effort. Simple ideas like supervised brushing can pay for themselves, but cash-strapped schools can't do it alone.”

According to the global study** commissioned by Unilever Oral Care, poor oral health damages children's teeth, lowers their self-esteem and harms their performance at school, at school.

Continued on page 11

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Childhood check-up campaign

Dental professionals in Scotland urged to promote DCby1

A CAMPAIGN by the British Society of Paediatric Dentistry, which is showing signs of success in combating early childhood caries (ECC) in England and Wales, is looking to have the same effect in Scotland.

Dental Check by One (DCby1) encourages parents and carers to take their children to a dentist for a check-up by the time they turn one.

Claire Stevens (pictured right), BSPD's spokesperson, said: "Dental Check by One was launched by BSPD in 2017. Its aim is to reduce the high levels of caries leading to high numbers of children requiring a general anaesthetic.

"During 2017-18, a total of 26,111 children in England aged between five and nine had a tooth – sometimes multiple teeth or full clearances – extracted under general anaesthetic.

"The annual cost to the NHS of these hospital episodes is more £50m. I am happy to say that there are early signs, however, that more children aged two or under are seeing a dentist in England."

Claire added: "Scotland has Childsmile and



Wales has Designed to Smile, and both include advice on getting children to the dentist by the age of one. The former CDO for Scotland was at the launch of DCby1 and we are delighted to say endorsed it. What's important about DCby1 is that it goes beyond dentistry and is being promoted by health visitors, pharmacists and other healthcare professionals. We urge readers of *Scottish Dental* to do everything they can to promote the campaign."

Resources can be found at www.bspd.co.uk/resources

Brexit staff shortage warning

SHORTAGES of skilled workers in Scotland across key sectors of the economy such as health and social care will be made worse after Brexit, Migration Minister Ben Macpherson has said.

The warning forms part of the Scottish Government's recent submission to the UK Government's Migration Advisory Committee about occupations officially classed as suffering from staff shortage.

The Scottish Government published evidence on a range of sectors, including a report focused on issues facing health and social care. As yet, dentistry is not among the professions listed but professional bodies are keeping a watchful eye in case that situation changes.

Thomas 'Tommy' Leca

SCOTTISH dentistry has a lost highly regarded and respected figure with the sad passing at the end of March of Thomas "Tommy" Leca, the founder of Leca Dental.



Tommy started Leca Dental with only a very small number of staff but it grew to become one of the largest dental laboratories in Scotland.

Tommy was known for bringing many people into dentistry, training apprentices and supporting them into colleges and universities. Many of these are now working across Glasgow and the Central belt, some of them business owners themselves. Tommy always took time to sit with his staff to help them progress and support them to achieve their aims and ambitions. Dental technology was Tommy's way of life and he retained his passion for his job throughout his career.

He will be missed by everyone at *Scottish Dental* and we send our sincere condolences to his wife and family.

How poor oral health affects children

Continued from page 9

The report, published for World Oral Health Day on March 20, shows the quality of a child's oral care can have an impact beyond obvious medical problems like bad breath and dental pain.

Tooth decay is the world's most widespread disease according to the World Health Organisation; the study shows most children across the globe have experienced oral pain in the past year, with one-third reporting this pain to be moderate to severe.

Those with poor oral care are more likely to have lower self-esteem (49 per cent compared to 32 per cent of those with good oral health); their lack of confidence and lower sense of self-worth affects the way they feel and behave in many different ways. From participation in class to making friends, the study reveals that children who don't take care of their teeth are having more problems in all aspects of their life.

Professor Nigel Hunt of the UCL Eastman Dental Institute in London emphasised: "It is appalling that in the 21st century dental decay remains the most prevalent chronic disease throughout the world, affecting both children and adults, when it's at least 90 per cent preventable. Despite an awareness of the importance of twice daily tooth brushing, the disease remains unchecked."

**The FDI survey was undertaken by YouGov Plc. Total sample size was 16,477 adults of which 4,367 were parents with children aged 5-16. Fieldwork was undertaken between 18th February – 4th March. The survey was carried out online.*

***The Unilever survey was carried out with children aged 6-17 years old and their parents across eight markets: Chile, Egypt, France, Italy, Indonesia, US, Ghana, Vietnam. There was a total of 4,000 respondents (500 from each market)*

Newcastle student claims second win for university

NEWCASTLE University student David Cobbett has been named as the national Dental Clinical Skills Competition winner.

It is the second year running that a Newcastle University student has won the grand final following Joe Reid's win in 2018.

The competition is run by the Royal College of Surgeons of Edinburgh (RCSEd) and sponsors Dentsply Sirona. The RCSEd President, Professor Mike Griffin, was delighted that for the last two years, the winners have come from Newcastle where he was Professor of Surgery.

Following his win at the Grand Final, held at the college on 28 February, David said: "I wasn't expecting it, I didn't think I'd done well. It was a great opportunity to practice practical skills we don't often get to experience.

"I am very interested in learning more advanced aspects of dentistry after I graduate and so I hope that courses provided by the college could help me with that."

The Dean of RCSEd's Faculty of Dental Surgery, Professor Fraser McDonald, said: "This unique competition offers aspiring young dentists the opportunity to take on practical evaluation by a series of challenges not often seen in their normal environment.

"The prestigious setting of the Royal College offers a distinctive backdrop; welcoming the young students and



David Cobbett and Professor Fraser McDonald

“ I AM INTERESTED IN LEARNING MORE ADVANCED ASPECTS OF DENTISTRY AFTER I GRADUATE AND SO I HOPE THAT COURSES PROVIDED BY THE COLLEGE WILL HELP ME WITH THAT”

encouraging information sharing and friendships forming that are likely to be lifelong.”

Michael Davidson, Clinical Lead at Dentsply Sirona, added: "The competition gives Dentsply Sirona the opportunity to engage with final year dental students in a very positive way. Professional development, innovation and oral health improvement are central to what Dentsply Sirona do."

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Award partnership with Faculty of Dental Trainers

SCOTTISH Dental has partnered with the Faculty of Dental Trainers for the Trainer of the Year award at this year's Scottish Dental Awards. The award will be supported jointly by *Scottish Dental* magazine and the Royal College of Surgeons of Edinburgh (RCSEd). RCSEd's Faculty of Dental Surgery launched its Faculty of Dental Trainers (FDT) in 2016.

Speaking about the partnership, Sarah Allen, Editor of Connect's *Scottish Dental* magazine said: "In common with FDT's core aims and principles, the Trainer of the Year award recognises the trainers who promote the highest standards of dental training, safeguard patient care and safety, and go the extra mile for their trainees; those individuals who create a positive learning environment for their trainees, whatever their discipline or career stage.

"All the awards celebrate the best of dental practice and patient care in Scotland and look for individuals and teams who place their patients at the heart of everything they do and continuously inspire, innovate and lead to deliver excellent patient care, to develop and enhance the dental profession and, ultimately, to improve oral health in Scotland."

The Director of the Faculty of Dental Trainers of RCSEd, Sarah Manton, added: "Aligning with *Scottish Dental* as partners to support the Trainer of the Year award demonstrates our mutual commitment to encouraging, recognising and rewarding the highest standards of training.

"FDT works to this aim by rewarding interest, engagement and achievement in dental training, providing support and guidance for career development in dental training."

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NEWS
IN BRIEF

Dental Access Initiative revisions

The latest revisions to the Scottish Dental Access Initiative (SDAI), which took effect from 1 April 2019, have been published. The revisions outline the designated areas of Scotland where financial assistance will be available to expand or purchase existing NHS dental practices. From 1 April, offers of financial assistance, under the SDAI to establish new or expand or purchase existing NHS dental practices will be available only in the following designated areas where access to

GDS availability is poor, i.e. in order to meet unmet patient demand: Invergordon, Wick, Nairn and Lochgilphead (NHS Highland); Dalmellington and Patna within (NHS Ayrshire) and Arran; Lerwick (NHS Shetland).

NHS dentists not the happiest

Results from the 2018 NHS Confidence Monitor survey, carried out by Practice Plan, have shown worrying statistics around levels of anxiety and unhappiness in the dental profession. The survey was open to both NHS and private dentists and respondents came from England, Scotland, Wales and Northern Ireland. It included questions about their levels of happiness across seven areas of their working life, anxiety about the risk of complaints and litigation, and their confidence in the future of NHS dentistry.

Across the seven happiness questions, the average percentage of NHS dentists saying they were either unhappy or very unhappy was 86 per cent. This contrasted dramatically with those practicing predominantly in the private sector, where the average percentage saying they were happy or very happy was 83 per cent.

Medics Against Violence

Scottish Dental is delighted to be supporting Medics Against Violent (MAV) at this year's Scottish Dental Awards. When Medics Against Violence was founded in 2008, medics in Scotland were on the front lines, handling the awful consequences of violence daily. Although medics were good at treating the injured it did leave some with scars, disabilities and psychological

trauma. Healthcare professionals came from all backgrounds to join the campaign to reduce violence.

Medics Against Violence aims to prevent violence before it happens. The healthcare professionals who are our members and volunteers use their knowledge, experience and skill to educate people to stay safe and teach the consequences of violence.

Pioneers honoured

A plaque has been unveiled at the University of Birmingham's School of Dentistry to celebrate two dentists whose work has helped save thousands of lives. It pays tribute to university alumnus Harold Round and his colleague Arthur Parrott who helped to develop an early version of the airbag to prevent impact jaw fractures during the First World War.



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Mr Martin Paley

BDS (Dund) 1989, MB ChB, FFDRCSI, FRCS, FRCSEd (OMFS), GDC No. 64778
Consultant Oral & Maxillofacial Surgeon

Martin's main NHS area of interest is Head & Neck Cancer performing complex reconstruction and Oral Rehabilitation using free tissue transfer techniques and Dental

Implantology. Martin accepts referrals at EDS for Oral Surgery and Dental Implant related cases.



Dr Gillian Ainsworth

BDS (Sheff) 1996 FDS RCSPG, MSc, MSurgDent, GDC No. 71932
Specialist Oral Surgeon

Gillian became one of the first two surgeons to complete the new specialist training program in Surgical Dentistry. Gillian is a recognised Oral Surgery Specialist, and accepts referrals for Oral Surgery, sedation and Dental Implant related cases.



Dr Suzanne Lello

BChD Hons (Leeds) 2008, MFDS RCS (Ed), MJDF RCS(Eng), FHEA, MOral Surg RCS (Eng) GDC No. 153633
Specialist in Oral Surgery

Suzanne has been working in the field of Oral Surgery for 10 years and completed her specialist training in 2015. She is currently developing a Postgraduate Certificate for the University of Edinburgh and accepts Dentoalveolar and Sedation referrals at EDS.



Professor Lars Sennerby

Tandläkare Gothenburg 1986
GDC No. 72826
Professor in Implantology

Lars trained in Oral Surgery at the Branemark Clinic in Gothenburg, which served as an international centre for clinical work, research and education regarding treatment of

edentulous patients with Dental Implants. Professor Sennerby is one of a handful of Clinicians in the world who has the title Professor in Implantology.

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- Wisdom Teeth, Impacted Teeth, Sedation.

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Welcome Orthodontist Dr Imran Shafi



DR IMRAN SHAFI
BDS, MFDS RCPS (Glasg), FDS RCS (Edin),
MOrth RCS (Edin), Doctorate in Clinical
Dentistry (Orthodontics), PG Cert Med Ed,
FHEA GDC No. 79325

Imran is a registered Specialist in Orthodontics and studied dentistry at University of Glasgow, qualifying in 2001. He has worked in general dental practice in the UK and Australia, with his specialist training undertaken at Glasgow Dental Hospital and School obtaining his specialist Membership in Orthodontics qualification in 2011 from the Royal College of Surgeons of Edinburgh and a Doctorate degree in Orthodontics from the University of Glasgow. Imran has won two prestigious prizes: from the Royal College of Physicians and Surgeons of Glasgow as the T.C White Lecturer Award and the Royal Society of Medicine Odontology President's Prize Award.

Outside of orthodontics Imran tries to keep fit by running and is a sci-fi geek, He is a trustee for the charity Dental Aid Network that provides dental volunteering missions to areas of high need including orphanages, refugee camps and vulnerable people.

Welcome Mary Downie

Mary recently joined Scottish Centre for Excellence in Dentistry, bringing a wealth of experience. In 1980, she qualified as a dentist in Glasgow and had a long and happy career in general practice and hospital dentistry. Throughout her career, she has had a keen interest in patients who suffer from dental anxiety and also patients who have oral facial pain. She is greatly interested in how the mind and body are inter-related.

In 2001, she qualified with an Honors degree in psychology and went onto complete a postgraduate diploma in counseling and psychotherapy. She also had training in hypnotherapy, CBT, mindfulness and EMDR. All of these therapies can play a part in helping dental patients. Hypnosis can be used very successfully in patients who have a fear of getting dental treatment. EMDR can also offer resolution for patients suffering from dental anxiety.



MARY DOWNIE
BDS, (Glasg)



10 Year Anniversary

Arshad Ali and Dr Scot Muir were delighted to host Scottish Centre for Excellence in Dentistry 10 Year Anniversary at the prestigious Rosshdu House at Loch Lomond Golf Club on Saturday 16th February 2019. Clinicians and their partners along with all Centre staff celebrated the success of SCED with a night of good food, good wine and of course good entertainment provided by the one and only Ian Wilson from IWT Dental. There were numerous prizes up for grabs along with a generous donation of a star prize from Ian and Bruce at IWT.

We would like to extend our thanks to all of our patients, referrers and suppliers for their outstanding continued support over the years.

Xguide Training

Always learning and eager to develop their skills, Arshad Ali and Dr Scot Muir attended a three day course in Rome with Prof Alessandro Pozzi. There was an exclusive xguide live surgery preview on the new implant and abutment surfaces from Nobel Biocare.

Geistlich Live Surgery GBR Masterclass Saturday 8 June 2019 at Scottish Centre for Excellence in Dentistry, Glasgow

Geistlich Biomaterials is hosting a morning of lectures, live surgery and hand-on with two of the UK's most experienced Implant Dentists, Dr Colin Burns and Dr Scot Muir. The event includes lectures, live surgery and hands-on.

Learning content:

- Develop an understanding of the biological processes that are involved in Guided Bone Regeneration.
- Be familiar with the surgical procedures involved in Guided Bone Regeneration.
- Be familiar with the biomaterials used in these procedures.
- Undertake hands-on training using an animal model of the Guided Bone Regeneration procedure, including the periosteal release.

Registration is just £199. To register or for more information email info@geistlich.co.uk or call +44 (0) 161 490 2038



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e enquiry@scottishdentistry.com



AWARD
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SCED Clinicians

MR ARSHAD ALI

Clinical Director / Specialist in Restorative
Dentistry & Prosthodontics
BDS, FDSRCS (Eng & Edin), FDSRCS (Glas), DRD, MRD
RCS (Edin)
GDC No. 52076

DR SCOT MUIR

Director / Special Interest in Restorative
Dentistry & Implantology
BDS, (Glas), M.F.G.D.P. RCS Eng, M.Sc (Warwick)
GDC No. 72214

DR ABID FAQIR

Special Interest in Restorative Dentistry & Implantology
BDS (Glas), MFDSRCS (Edin), MSc (medsci)
GDC No. 75815

DR MARK LANG

Special Interest in Endodontics & Restorative Dentistry
BDS (Glas), M.Sc (Glas), MJDF, RCS (Eng), MRCPSG
GDC No. 66529

DR COLIN BURNS

Special Interest in Restorative Dentistry & Implantology
MFDS RCS Eng 2005
BDS Glasg 1990
GDC No. 65349

DR KEVIN O'FARRELL

Special Interest in Restorative Dentistry & Implantology
BDS (Glas), MJDF, RCS (Eng), MSc (UCLan) Aesthetic Dental
Implantology
GDC No. 152184

MR ANDREW CARTON

Consultant Oral & Maxillofacial/Head & Neck Surgeon
MA, FFDRCS, FDSRCS (Glasg), FRCS (Maxfac)
GMC No. 3575882

DR LORNA COX

Special Interest in Restorative Dentistry & Periodontology
BDS (Dundee) 2001
RCS (Edin) 2004
MSc Primary Dental Care & Perio (Glas) 2011

SAMEENA RASHID

BScmedsci(hons), MBChB(Gla), MRCS (Ed)
GMC No. 6026574

MARY DOWNIE

BDS, Glasg

DR IMRAN SHAFI

BDS, MFDS RCPS (Glasg), FDS RCS (Edin), MOrth RCS
(Edin), Doctorate in Clinical Dentistry (Orthodontics), PG
Cert Med Ed, FHEA
GDC No. 79325

LOUISE WARDEN

Dental Hygienist
Dip Dent Hygiene Glasg 2004
GDC No. 6564

CATRINA MACINTOSH

Dental Hygienist
CEB Cert in Dental Hygiene 1984
GDC No. 2800

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referred
patients
within
2 weeks

2

DATES FOR YOUR DIARY

25 APRIL

Traumatic dental injuries:

Fractures

Webinar 1pm

Royal College of Physicians and Surgeons of Glasgow (RCPSG) – Glasgow*

26 APRIL

Training essentials - Management of medical emergencies in the dental practice

BDA, London***

2 MAY

BDA Presidential Meeting and AGM

BDA, Wimpole Street, London***`

9 MAY

Clinical Trainer development: An Overview

Royal College of Physicians and Surgeons of Glasgow*

9-10 MAY

Dental Cone Beam CT Course

Level 2A Certification
Royal College of Physicians and Surgeons of Glasgow (RCPSG) – Glasgow*

9-10 MAY

NHS Education Scotland Dental Education Conference

Edinburgh International Conference Centre

13-14 MAY

Royal College Advanced Certificate in Clinical Education,

In Glasgow
Royal College of Physicians and Surgeons of Glasgow (RCPSG) – Glasgow*

17-18 MAY

British Dental Conference and Dentistry Show

Birmingham NEC

20-21 MAY

Training the Clinical Trainer

Royal College of Physicians and Surgeons of Glasgow (RCPSG) – Glasgow*

23 MAY

Traumatic dental injuries:

Displacements

Webinar 1pm
Royal College of Physicians and Surgeons of Glasgow (RCPSG) – Glasgow*

31 MAY

Top Tips for GDPs

Royal College of Physicians and Surgeons of Glasgow (RCPSG) – Glasgow*

21 JUNE

Preparation Course for the Tri-Collegiate Membership in Paediatric Dentistry Examination

Royal College of Surgeons Edinburgh (RCSEd)**

27-28 JUNE

Royal College Advanced Certificate in Clinical Education

26-27 APRIL

Scottish Dental Show

Braehead Arena, Glasgow
G51 4BN
www.sdshow.co.uk

In Leeds

Royal College of Physicians and Surgeons of Glasgow (RCPSG) – Glasgow*

11 OCTOBER

IGDP (UK) National Study Day: Strategies for the Future Dental Patient

Etihad Stadium, Manchester

* More information for RCPSCG events at: <https://rcpsg.ac.uk/events>
Webinars: <https://rcpsg.ac.uk/elearning/product/dental-webinars-package>

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

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

Two day course: Practical Introduction to Occlusion

This 'hands-on' two day course has been designed to teach you how to design and manage the Occlusion in every situation.

From a single restoration to a full arch on Dental Implants; from worn teeth to periodontally mobile teeth, you will be tasked with practicing the techniques from day 1 to allow for greater understanding on day 2.

Thursday 9th May and Thursday 23rd May 2019

£990 including all materials, laboratory support and lunch at a local bistro.

To book your place or for more information please contact Gemma 0131 225 2666 or gemmagrant@edinburghdentist.com

Numbers are limited to allow full participation. All delegates benefit from long term 'tele-dentist' support.



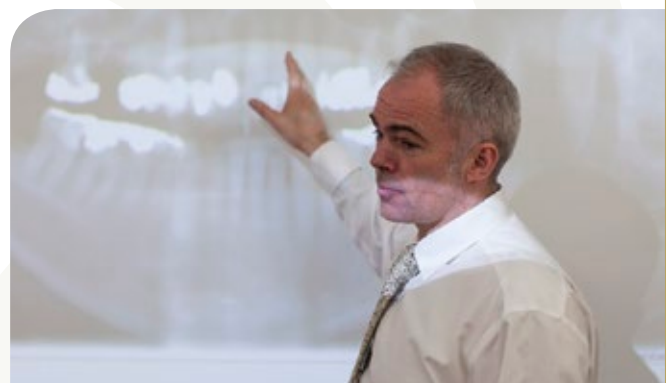
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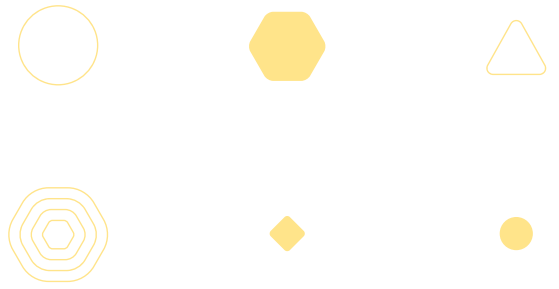
We have run this course over many years with great success. Previous delegate feedback:

“A lot of light bulb moments – Occlusion simplified. Thanks for a great course.”

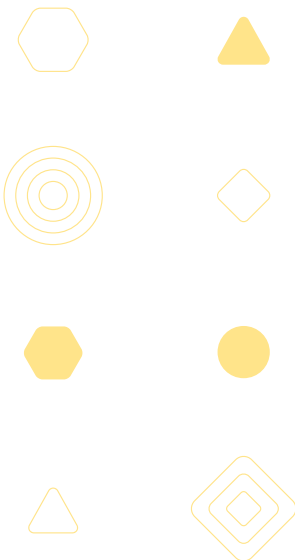
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glasgoworthodontics.co.uk



Simon Miller
GDC No. 57917
BDS (Glasgow 1983),
FDS, MSc, MDO, RCPS



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MFDS, MSc, M.Orth, RCS



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MFDS, MSc, M.Orth, RCS



Sheena Macfarlane
GDC No. 53199
BDS (Glasgow 1979), BSc



Paul Mooney
GDC No. 178517
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Turnover
£429,955

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FREE valuation





What a Show!

2019's Scottish Dental Show: have you signed up for the industry event of the year?

Once again, record numbers of delegates are heading for Braehead Arena on 26-27 April 2019 for the eighth Scottish Dental Show. Well over 2,000 dental professionals will come through the doors, up 10 per cent on last year, attesting to the show's growing popularity and cementing its importance.

It's not just the delegate numbers that have grown – the Show's educational programme, which provides dental professionals with valuable learning opportunities through the wide range of lectures, talks and workshops.

This year 36 lectures and 27 workshops will provide delegates with the opportunity to gain up to nine hours of Enhanced Continued Professional Development over the

two days. We are delighted to have some of the leading lights of the profession share their expertise. Consultant Oral and Maxillofacial Surgeons Roger Currie and Stuart Clark will talk about the early detection of oral cancer and medical emergencies in dental practice respectively.

Dr Christine Park, Senior Clinical University Lecturer and Honorary Consultant in Paediatric Dentistry at the Glasgow Dental School, will talk about child protection, and we are also delighted to welcome Professor William Saunders, Emeritus Professor Endontology at the University of Dundee, to speak on root canal obturation. Captain Karl Ley, a bomb disposal expert from the British Army, will speaking about stress and burnout in high-pressure roles.

Delegates will also have the opportunity to learn about



Create a personalised Scottish Dental Show timetable at www.sdshow.co.uk



2019: OUR BIGGEST EDUCATION PROGRAMME YET

The educational programme at the 2019 Scottish Dental Show will provide verifiable CPD lectures and workshops relating to the GDC's recommended eCPD topics. Spaces are strictly limited so book your place ASAP at www.sdshow.co.uk

Friday

Christine Park

Safeguarding and child protection for dental teams
09.00-10.00, Speaker room 1

How to recognise signs of abuse and neglect, understand your responsibilities, GDC requirements and appropriate referral pathways.

Development outcomes A D

Peter Ommer

The PDS: to infirmity and beyond
10.45-11.45, Speaker room 1

The services provided by the Public Dental Service and where it fits in the continuum of care.

Development outcomes A B D

Christine Goodall

Repairing the scar on the face of Scotland
10.45-11.45, Speaker room 2

Christine Goodall talks about Medics against Violence, the Scottish violence prevention charity she founded.

Helen Kaney

Regulation of the dental team – where are we now?
10.45-11.45, Speaker room 3

Understand the General Dental Council and find out how (and how not) to get into trouble.

Development outcomes A D

Donald Thomson

Radiography and radiation protection
12.15-13.15, Speaker room 1

The risks of ionising radiation and doses received in dentistry, plus IRR, IRMER 2017 and their protective role.

Development outcomes B C D

Toby Gillgrass

Orthodontics, referral and treatment
12.15-13.15, Speaker room 2

What you should refer - and when you should refer patients - for treatment within the specialist service.

Development outcome C

the latest technology, developments and services from some of the biggest names in the industry as we have 140 organisations exhibiting in the main hall this year.

And then there is the annual 2019 Scottish Dental Awards Ceremony and Dinner, celebrating the best of dental practice and patient care. The awards, hosted by comedian Fred MacAulay, are held at the Glasgow Hilton Hotel on Friday April 26 and recognise individuals and teams who place patients at the heart of everything they do and inspire, innovate and lead to deliver excellent patient care, improving oral health in Scotland.

This year the number of categories has risen to 14 to recognise wider best practice within the profession. In addition to the coveted Scottish Dental Lifetime Achievement Award and Clinician of the Year award, there are Leadership and Trainer of the Year award, Referral Practice of the Year and Practice of the Year.

It's a must-attend event, so if you haven't registered yet for the Scottish Dental Show or the Scottish Dental Awards, go to www.sdshow.co.uk.

We look forward to seeing you there.



Continued on page 22





Scottish Dental SHOW 2019

Dentsply Sirona are launching the new Primescan technology at the Show



Continued from page 21

Helen Kaney

The risks of advertising and social media

12.15-13.15, Speaker room 3

Understand UK advertising standards and relevant GDC guidance to minimise risk to practice and reputation.

Development outcomes A B D

Captain Karl Ley, British Army

Stress and burnout in bomb disposal

14.15-15.15, Speaker room 1

Captain Ley made safe 139 improvised bombs on a single tour in Afghanistan. Find out how he coped with stress.

Development outcomes B

Lee McArthur

Infection prevention and control update

14.15-15.15, Speaker room 2

Why infection control is important, difficulties in standard control precautions and recent changes.

Development outcomes C D

Douglas Hamilton, MDDUS

The only way is ethics

14.15-15.15, Speaker room 3

How ethical is your practice's approach to core biomedical principles and does it match up to legal or GDCI standards?

Development outcomes A C D

Professor William Saunders

Root canal obturation

15.45-16.45, Speaker room 1

A review of the role of obturation in the

prognosis of root canal treatment and update on appropriate methods.

Development outcomes C D

Sarah Harford, MDDUS

A matter of consent

15.45-16.45, Speaker room 2

Understand consent and why we need it, the components of valid consent, legal requirements and who can give consent.

Development outcomes A C D

Tamara Sherwood, Leona Beecroft, Faculty of Dental Trainers (FDT)

The ABCDE approach to the assessment of the acutely unwell patient

EDUCATION FDT STREAM

15.30-16.30, Speaker room 3

A series of Interactive Mentimeter presentations on how and why the ABCDE approach should be used, an examination of ABCDE assessment elements and sub-elements, plus ABCDE data and action pause points.

Development outcomes A B C D

Saturday

Roger Currie

Oral and skin cancers - early detection and recognition

09:00-10:00, Speaker room 1

Signs and presentations of oral and skin cancers to aid recognition and referral.

Development outcomes A C D

Stuart Clark

Medical emergencies

09:00-10:00, Speaker room 2

The preparation and management of medical emergencies.

Development outcomes B C D

Lee Savarrio, Andrew Forgie

NHS Drivers for Change and Shared Care Lecture

EDUCATION GDH SHARED CARE

STREAM 09:30-10:30, Speaker room 3

An overview of undergraduate students' work at Glasgow Dental School.

Development outcomes A

Roger Currie

Oral and skin cancers - early detection and recognition

10:45-11:45, Speaker room 1

Signs and presentations of oral and skin cancers in order to aid recognition and referral.

Development outcomes A C D

Stuart Clark

Medical emergencies

10:45-11:45, Speaker room 2

The preparation and management of medical emergencies.

Development outcomes B C D

Gareth Calvert, Douglas Robertson, Shauna Culshaw

Shared care - endo/FRP/Perio

EDUCATION GDH SHARED CARE

10:45-11:45, Speaker room 3

Glasgow Dental Hospital team leaders discuss the changes in service delivery by the Departments of Endodontics, Prosthodontics and Periodontics in Glasgow Dental Hospital.

Development outcomes A B



Clive Schuliman offers a workshop on suturing.

Ulpee Darbar

Clinical standards in implant dentistry – what are they?

12:15-13:15, Speaker room 1

An overview of the clinical standards in implant dentistry and their link into good clinical practice with tips on how to integrate this into day to day care.

Development outcomes A C D

Beth Burns, Angela McGee, David Conway

Shared care – trauma/DCP/research EDUCATION GDH SHARED CARE STREAM

12:15-13:15, Speaker room 2

To discuss how Glasgow Dental Hospital Restorative Department will provide a service for acute adult dental trauma, the service and teaching provided by the DCP school in Glasgow Dental Hospital and how the Restorative Department contributes to the University of Glasgow research.

Development outcomes A B D

Aubrey Craig

When patients bite back – successful complaint management

12:15-13:15, Speaker room 3

The principles of complaint management, how to achieve local resolution and the regulatory pathway should the complainant remain dissatisfied.

Development outcomes A B D

Helen Patterson

Protecting adults at risk

14:15-15:15, Speaker room 1

An overview of legislation regarding adults at risk, types of abuse and our responsibility to report concerns.

Development outcomes A D

Gareth Calvert, Victoria Harper, Allan Donaldson

Shared care – Hypodontia/H&N/ Cleft

EDUCATION GDH SHARED CARE STREAM

14:15-15:15, Speaker room 2

To explain the journey of patients with hypodontia, head and neck cancers, cleft lip and palate in the Restorative Department of Glasgow Dental Hospital.

Development outcomes B C D

Rachael Bell, MDDUS

How to land your plane on the Hudson – learning points in risk management

14:00-15:00, Speaker room 3

How to react when things go wrong in general dental practice.

Development outcomes A B D



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Friday

Liam McMonagle, Thorntons Law LLP

What Brexit will mean for dentistry in Scotland
09:30-10:30, Speaker room 3

Martyn Bradshaw, PFM Dental and Michael Roydon, Thorntons Law LLP

What is your practice worth?
09:30-10:30, Speaker room 4

Craig Sinclair, Davidson Chalmers

Buying and selling dental practice
10:45-11:45, Speaker room 4

Scott Lawson, Martin Aitken Financial Services Limited

Financial and pension planning for dentists at all stages of your career
12:15-13:15, Speaker room 4

Louise Grant, Anna Coff, EQ Accountants

Tax update: IR35 and Making Tax Digital
14:15-15:15, Speaker room 4

Amy Jones, Thorntons Law LLP

Managing poor performance
15:30-16:30, Speaker room 4

Saturday

Martyn Bradshaw, PFM Dental, Jon Drysdale Financial Advisor, and Michael Roydon, Thorntons Law LLP

Buying a dental practice – what you need to know
09:30-10:30, Speaker room 4

Roy Hogg

Hot topics for dentists including tax savings, accounts and business advice
10:45-11:45, Speaker room 4

Kim Campbell, Thornton LLP

Top 10 legal issues in dental practices
12:15-13:15, Speaker room 4

Gurjit Pall

What Brexit will mean for dentistry in Scotland
14:00-15:00, Speaker room 4



Roy Hogg will give advice on tax savings.

WORKSHOPS: LEARN NEW SKILLS

Hands-on workshop sessions provide updates on the latest skills and hardware



Phil Friel offers two workshops on dental implants.

Friday

Phil Friel, Advanced Dentistry
The restoration of dental implants
09.30-10.30, Atrium 1
Development outcomes A C D

Calcivis/ Flo Couper and Leanne Branton
The CALCIVIS® imaging system
09.30-10.30, Atrium 2
Development outcomes B C

Charlie Laity, 3Shape
3Shape indirect bonding
09.30-10.30, Atrium 3
Development outcomes B C

Paul Reaney
Digital techniques for the management of snoring and Sleep Apnoea
10.45-11.45 Main arena
Development outcomes B C

Karen Parker
Innovation within Oral Health Improvement
10.45-11.45, Atrium 1
Development outcomes A B C

Christine Park
A serious game for the dental team with an emphasis on safeguarding children
10.45-11.45, Atrium 2
Development outcomes A D

Dr James Robson, Voco
Giving your restorative dentistry the edge
10.45-11.45, Atrium 3
Development outcomes A D

Dr Eimear O'Connell
Dentsply Sirona Primescan Launch
12.15-13.15, Atrium 1
Development outcomes B

Christine Park
Safeguarding tools
12.15-13.15, Atrium 2
Development outcomes A D

Paula Mann, Emma Ravichandran, Aesthetic Training Academy
The full face approach to non-surgical rejuvenation Part 1
12.15-13.15, Atrium 3
Development outcomes B C

Paul Reaney, Snoring Solutions NI
Digital techniques for the management of snoring and Sleep Apnoea
14.15-15.45 Main arena
Development outcomes B C

Clive Schmulian, Greygables Dental
Suturing in dental practice
14.15-15.15, Atrium 1
Development outcomes C D

Leona Beecroft, Tamora Shemwood, Faculty of Dental Trainers
Team confidence in a medical emergency
14.15-15.15, Atrium 2
Development outcomes A B C D

Optident
Bonding + Bioclear
14.15-15.15, Atrium 3
Development outcomes B C

Phil Friel, Advanced Dentistry
The maintenance of dental implants
15.30-16.30, Atrium 1
Development outcomes A C D

Dr Arvind Sharma, Dr Michael Davidson, Dentsply
Root canals and restorations – a roadmap to success
15.45-16.45, Atrium 1
Development outcomes B C D

Karen Parker
Innovation within oral health improvement
15.45-16.45, Atrium 2
Development outcomes A B C D

Saturday

Phil Friel, Advanced Dentistry
The maintenance of dental implants
Business 09.30-10.30, Atrium 1
Development outcomes A C D

Calcivis/ Flo Couper and Leanne Branton
The CALCIVIS® imaging system
09.30-10.30, Atrium 2
Development outcomes B C

Dale Flanagan, Pedro Pablo Rodriguez, 3Shape
3Shape smile design
Business 09.30-10.30, Atrium 3
Development outcomes A B C

Sarah Manton and Alastair Gerraghty
Human factors and non-technical skills in dentistry
EDUCATION FDT STREAM
10.45-11.45, Atrium 1
Development outcomes A B

Dr Eimear O'Connell, Dentsply Sirona
Dentsply Sirona Primescan launch event
10.45-11.45, Atrium 2
Development outcomes B

Clive Schmulian, Greygables Dental
Suturing in dental practice
10.45-11.45, Atrium 3
Development outcomes B C

Sarah Manton and Alastair Gerraghty
Development of a non-technical skills taxonomy in dentistry
EDUCATION FDT STREAM
12.15-13.15, Atrium 1
Development outcomes A B D

Paul Reaney, Snoring Solutions NI
Digital techniques for the management of snoring and Sleep Apnoea
12.15-13.15, Main arena
Development outcomes B C

Lee Savarrio, Glasgow Dental Hospital
Shared care - Peridontics
12.15-13.15, Atrium 2
Development outcomes A B

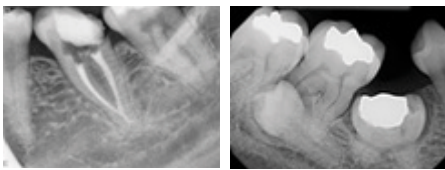
Suzanne Blacker, Glasgow Dental Hospital
Shared care - Endodontics
EDUCATION GDH SHARED CARE STREAM 12.15-13.15, Atrium 3
Development outcomes B C

Beth Burns, Glasgow Dental Hospital
Shared care - Trauma
EDUCATION GDH SHARED CARE STREAM 14.15-15.15, Atrium 1
Development outcomes B C

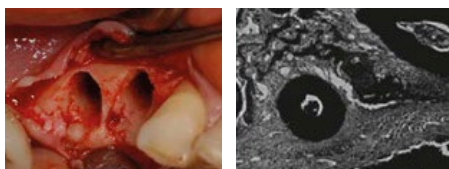
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Oral cancer is one of the fastest growing cancers in the UK. In the last 20 years, the diagnosis of this type of cancer, which affects the mouth and throat, has jumped 135 per cent, with 2,722 people losing their lives to the disease last year. These are the disturbing statistics from the State of Mouth Cancer Report 2018/19 published by the Oral Health Foundation last November during Mouth Cancer Action Month.

According to this survey, while almost nine in 10 (88 per cent) adults in Britain have heard of mouth cancer, only 8 per cent are confident about their knowledge of the disease. More concerning is that three in four (75 per cent) do not know the major signs and symptoms for mouth cancer.

That's why the vigilance of dentists and their

knowledge of oral cancer symptoms during routine inspections of their patients is vital to spot the disease early and improve the life expectations of people.

Early detection of oral cancer increases the chances of survival from 50 per cent to 90 per cent. Depending on where the cancer strikes, the one year survival rate for mouth cancer is between 60 per cent and 83 per cent. This drops to between 19 per cent and 58 per cent after 10 years.

Scottish Dental magazine spoke to three people who, to some degree, owe their lives to their dentists who either correctly identified oral cancer, or whose doubts led them to ask their patents to get a second opinion. Thanks to their dentists' intervention, and to the skills and dedication of the many medical professionals who were involved in their treatment and subsequent recovery, Peter, Susan and Alex are now living healthy and fulfilling lives once more. Here are their stories.



'I'm here thanks to the vigilance of a new dentist'

IF Alex Geater's regular dentist had not gone on holiday in April 2016, Alex believes he would not be alive today. The retired engineer, now 79, had been seeing his dentist to get new dentures fitted but had to go back several times over a period of a couple of weeks because they were still uncomfortable. When the dentist went on holiday a colleague took over Alex's treatment, but after a routine examination of his mouth the new dentist was concerned with what she saw.

Alex explained: "The new dentist said: 'I think we might have a problem here' and excused himself to make a phone call. And the next day I was asked to go to the Dental Unit of Monklands Hospital to get a biopsy."

The dentist had spotted small ulcers underneath Alex's tongue and had suspected cancer – a prognosis that was confirmed a few weeks later by specialist head and neck cancer consultant after a number of tests, CT scans and X-rays.

Alex said: "I thought something was up because of the speed I was asked to go back to hospital for repeated tests. When they confirmed it was cancer I was shaking. However, they were very good with me, explaining all the options they could take to tackle the cancer and in a language I could understand.

"They described the pros and cons of three options: chemotherapy, radiotherapy and surgery. So, after a chat with my wife Eleanor, who was a former nurse, I decided on surgery because I wanted the cancer out of me."

However, the surgery was not a simple operation of just removing the part of Alex's tongue affected by the cancer. It was a particularly invasive procedure: it involved accessing the lower part of his tongue through the right hand side of his neck, removing some of his shoulder muscle to gain access and taking a skin graft and artery from his arm to replace the part of the tongue that had to be cut away. Skin was also taken from his stomach to replace the material removed from his arm. The operation took 11 hours and he was told that a vast number of people were involved in preparing and conducting the surgery as well as those involved in his subsequent recovery.

Alex said: "I went into hospital on 10 May 2016, three days before the surgery, and one day I remember waking up and feeling odd. So I mentioned this to the nurse to see if I should go through with the operation and she laughed and said I had the surgery the day before. It was amazing, as I did not feel a thing."

After four weeks, Alex was able to return home but, as his mouth and neck needed to recover, he had to be fed a liquid supplement through a tube inserted through his nose for the next four weeks.

While the operation was successful there were physical consequences that Alex is still learning to get used to. A big change is the loss of his salivary glands and not being able to move his tongue.

He said: "I don't go anywhere without my artificial saliva spray which helps to hydrate my mouth. Also, as my tongue is effectively fixed to the bottom of my mouth I can't move it around, which makes chewing food and moving it around my mouth very difficult, which makes mealtimes a problem .

"However my wife is wonderful and blends all my food for me and also my pharmacist has helped by procuring liquid forms of all my medication."

Alex is now attending the Glasgow Dental Hospital to get dentures fitted, as his jawbone was slightly offset during the surgery, and is looking forward to chewing again.

Looking back on the experience, Alex said he is full of admiration for the way all the medical professionals worked together with such speed to find out what the problem was, deal with the cancer and have also continued to support him in his recovery.

This inspired him to get involved with Macmillan Cancer Support Lanarkshire and to use his experiences to help others. He is now a qualified advisor based at Bellshill Library where the charity holds a drop-in service.

He's also been involved in setting up a local support group at the Maggie's Centre, alongside Monklands Hospital.

He said: "Before this happened to me I had never heard of 'head and neck' cancer so I asked the Macmillan head and neck clinical nurse specialist and my speech therapy nurse, who were supporting me through my recovery, if I could meet someone else who had the same sort of operation. She set up a meeting between Eleanor and myself with another couple, and we had a brilliant afternoon taking about our experiences. We decided to meet monthly and since then other people have joined us; the last time we met we had 36 people in the room.

"It's a great forum to discuss issues and after I told them about how I deal with 'dry mouth' issue with my artificial saliva spray no one has that problem any more. We've even discussed the best way to prepare and eat food without it getting stuck to the top of our mouths."

He added: "I'm thankful that my regular dentist went on holiday when he did, but I'm also angry with him for not spotting the signs of cancer when I had seen him for repeated visits over those two weeks. The reason I'm here and supporting others with cancer is thanks to the vigilance of his colleague."





‘Now I would never have known that I had cancer’

IMAGINE a life without the pleasures of chocolate, cakes, biscuits and red wine. This is the reality for Susan Bookless, 60, who underwent a series of chemotherapy and radiotherapy treatments after she was diagnosed with oral cancer in 2017.

The treatment not only “fried” her saliva glands, giving her a constant dry mouth, but also changed her taste buds.

The retired businesswoman from Biggar explained: “My taste buds have not gone back to normal after the treatment for cancer. I used to absolutely adore chocolate but now it tastes utterly vile, the same with red wine. As I can’t produce saliva there are a lot of foods that just don’t suit me now like biscuits, crackers or cake, and it means that I have to drink a lot of water during the day and with my meals. Strangely, whisky still tastes nice!”

Susan’s experience started in late 2017 when she felt a lump in her neck. This was at the same time as she was having root canal treatment and having a crown fitted on her back tooth so she thought there might be some infection from the treatment. She mentioned this to her dentist who took an X-ray of the area but could not see anything unusual. The dentist thought the issue would probably resolve itself, but also advised Susan to go to her GP to get it checked out.

As the lump was still there a couple of weeks later, Susan went to see her GP who, although he was not unduly concerned, referred her to local hospital for an ultrasound scan just to check.

She said: “I thought it was possibly an infection or my glands were swollen because of a cold, but it wasn’t sore or uncomfortable at all. However, when the radiologist said to me that my GP would have the results of the scan tomorrow, I thought ‘oh dear, that’s a bit quick’.

“That was the Thursday and on the Friday evening my doctor phoned to say that there was an issue.

“I knew when I was having the scan that they had found something so from that moment onwards I really think I knew what it was. Like most people, I Googled everything I could find about throat cancer symptoms, so I was quite prepared for it.”

Susan was sent to Monklands Hospital where an ENT consultant used a camera to examine the inside of her throat and also did a needle biopsy, which was processed in half an hour.

Although the needle biopsy showed that Susan had cancer, the consultant wanted to take a ‘belt and braces’ approach and put her under a general anaesthetic to take a full biopsy. This confirmed that she had oropharyngeal cancer under the back of her tongue on the right hand side and that this had spread to her lymph glands on the same side – the lump that Susan had originally felt.

“At the time, I was totally prepared to hear that it was cancer. I just thought: it is what it is and I’ve got to get through it. I was more concerned about my husband and about telling my children and elderly parents. It was a shock to my husband as I’d only mentioned my suspicions to him the previous evening. Over the next two or three weeks, I did have a few meltdowns but that was just because of the enormity of the news.”

After further scans and consultations with an ENT consultant and an oncologist at the Royal Infirmary in Glasgow, Susan was referred to a Macmillan nurse who explained what the treatment would be over the six weeks of radiotherapy and two rounds of chemotherapy, which was to start in December 2017.

“The Macmillan nurse that was assigned to me was absolutely fantastic. She was a head and neck specialist so she knew exactly what I was going to go through and was there to give advice and support.

“The radiotherapy ended on 19 January. For the first couple of weeks of treatment, I felt fine but then, just as the Macmillan nurse had told me, I began to feel very poorly and my throat started to burn. By Christmas, I could not swallow and on Boxing Day I had to have a feeding tube inserted up my nose and down into my stomach, which is how I had to ‘eat’ for the next six months.

“During this time I was very sore and tired and really pretty nauseous. I had a sick bowl in every room in the house and even in the car.”

Despite these experiences Susan says she now feels absolutely fine. She said: “There’s no doubt about it, it is a brutal and horrific experience and it took about a year out of my life, but you soon forget it and you get back to some sort of normality.

“Today I feel absolutely great and, if it was not for the dry mouth, I would have never have known that I had cancer.”

Last November, Susan joined Alex Geater as one of the many people who attended the Scottish Parliament to support the British Dental Association Scotland action plan to combat oral cancers and also highlight that the government’s plans to extend the gap between dental appointments to beyond 12 months could jeopardise efforts to tackle Scotland’s fastest growing cancers.



I KNEW WHEN I WAS HAVING THE SCAN THAT THEY HAD FOUND SOMETHING SO FROM THAT MOMENT ONWARDS I REALLY THINK I KNEW WHAT IT WAS. I GOOGLED EVERYTHING I COULD FIND ABOUT THROAT CANCER SYMPTOMS, SO I WAS QUITE PREPARED FOR IT



‘The whole medical treatment was extraordinary’

PETER YOUNG was devastated after hearing he had been diagnosed with oral cancer, but the strong relationships he made with the medical professionals who were responsible for his treatment helped him to overcome one of the greatest shocks of his life.

After an international career in logistics, Peter had returned to Scotland to settle down with his family, but that plan was soon shattered after a routine visit to his dentist in Glasgow.

He explained: “I went to my dentist to get a tooth taken out two days before I was going on holiday but during her examination she said to me: ‘There’s something not right here – I’m going to refer you to the Dental Hospital’.

“I was not unduly concerned, but the next day the hospital called me and asked me to come in. As I was away for a week I met the dentist the following Monday and after a further examination she said there was something hidden under the back of my tongue that she was concerned about, and she referred me to the Head and Neck Department at the Queen Elizabeth University Hospital.”

The H&N consultant agreed that it needed further examination, and after two weeks of tests, scans and MRIs the consultant told Peter he was 99 per cent sure it was cancer, and the way forward was radical surgery.

Peter said: “I felt devastated. I did not know what radical surgery meant: radical was, as far as I was concerned, when I joined the CND (Campaign for Nuclear Disarmament)! My surgeon sat with me for an hour two weeks before the operation so we could discuss things and then asked me to sign the consent form. He also had the honesty to ask me to sign a second consent form because something could go wrong with the first operation and he did not want to bother my wife for further consent – and, sure enough, something went wrong.”

The surgery involved a tracheostomy and a selective neck dissection where they split Peter’s jawbone to get access to the cancer at the back of his throat. This also involved removing his teeth and taking skin and a vein from his forearm to graft onto the area at the back of his mouth where the cancer had been removed. After 11 hours of surgery, which ended with his jaw bone being fixed back in position, it should have been a case of slow recovery, but another operation was required to clean out the neck dissection. Also, the skin graft removed from this arm became infected.

Peter said he was shocked when he looked in the mirror for the first time after the surgery: “I looked like I’d been in a car crash. They had split me half way down my chin and took half that jaw bone away and then reconstructed it all, but they had done such a good job that my face eventually became symmetrical. I came out looking better than I went in.

“The whole medical teamwork was

extraordinary. There were lots of people from the consultant, surgeons and nurses right down to the speech therapist who taught me how to speak again. They were so professional and caring, which I think is a rare combination.”

After three and a half weeks in hospital Peter returned home. While he was physically recovering well he was mentally shattered by the experience and this affected his behaviour.

He explained: “My consultant said that my life would change from this moment onwards but I did not believe him. But it did change and he was right because all of a sudden you realise that you are mortal – and that is a difficult thing to accept.

“When I got the diagnosed I found the whole thing very distressing. The biggest reaction that you have is mental. The physical pain you experience is nothing compared with what goes on in your head. I think you go into a survival mode so I strongly felt I was going to live, whatever happens.

“The problem starts when you go home and you take it out on the people that you love; you become very short-tempered and very selfish. It took me about a year to realise what I had become and apologise to my wife. She says I’m much nicer now!”

Peter was able to get support and advice from his consultant who he saw every six weeks, and particularly from the senior nurse at the Queen Elizabeth University Hospital where he went regularly for checks on the infection on his arm.

He said: “This senior nurse’s father had gone through the same cancer as me so she insisted on treating me herself and checking up on me and making sure I was dealing with the experience. That regular interaction with her helped me get back on the right path – she was like my psychologist.”

Although Peter went back to work, after a year he was due to take retirement. He said: “I just wanted to get back into normality and into a rhythm, but after a trauma like this your confidence goes – your mind does funny things.”

He is not idle in retirement, and he is using his own experience of surviving cancer to help others as he has trained as a Macmillan Cancer Support adviser.

He said: “I do a bit of work for Macmillan on counselling people at a library. You can visibly see the relief in people’s faces when they realise that you have been through the same experience as them and that you know what you are talking about – it creates immediate empathy.”

He added: “The consultant said I was fortunate that they found the cancer early on as I had a 90 per cent chance of survival to live more than five years. I was discharged from hospital on 14 August 2015 so it’s coming up for four years now, so I’ll never forget my dentist for spotting something and having the sense to refer me on.”



A Scottish enlightenment

In the second of our series of interviews examining the status of dentistry in the political and policy frameworks of Scotland, our editor, Sarah Allen, speaks to Alex Cole-Hamilton, MSP for Edinburgh West, Scottish Liberal Democrat spokesperson for health, and member of the parliamentary Health and Sport Committee.

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In the interests of full disclosure, I should start by saying that Alex Cole-Hamilton is my local MSP; his children even go to the same local primary as my children. But this was not why I wanted to speak to him in this series. As dentistry is not an area of healthcare that politicians speak about very often, when we do hear anything about dentistry in Scotland from political circles, it all tends to be through the prism of Scottish Government and we very rarely hear anything from the other parties, even from their health spokespeople. I'd never met Alex before this interview, in any context, so I was therefore very keen to hear from him as a politician with no background in health or dentistry, and in light of his health portfolio, to gauge his understanding of the issues facing dentistry, to see how often these crossed his desk, and whether he had faith that dentistry held its rightful place within healthcare among his political colleagues, of all parties. I started with my now customary opening gambit, what place does dentistry hold in the political consciousness of Scotland?

"I think it is a Cinderella specialty in many ways. I think that is evident in the fact that we still don't have a Chief Dental Officer," said Alex. "The fact that Margie still has not been replaced speaks volumes about the amount of priority the government affords to this agenda. Also, we've got notional workstreams within the Scottish government like the Oral Health Improvement Plan (OHIP) but there's not really a timeline as to how that's to be reviewed or whether the Health Committee can even take evidence to review the efficacy of the OHIP. That is something I and other colleagues in opposition parties have asked clerks, so I hope we will have an opportunity to road test how that's going."

Well, not the most positive of starts, but the lack of both a permanent CDO and of any information about the progress and next steps of the OHIP have been causing increasing concern with practitioners and dental organisations alike. Perhaps dentistry just isn't considered that important by people who are not exposed to it very often. Do Alex and his colleagues understand the critical importance of dentistry within the healthcare landscape, and the very real issues that it faces?

"Dentistry is really important, and it is about far more than just dental health. Dentists are often the first people to catch early signs of oral cancer. They can flag up concerns about vulnerable patients, and they may well be the first person that patient has seen for a while, meaning the dentist will be able to spot other health issues through that contact. I think also the landscape is very different than other professions within the health service because of the fine balance between the private and NHS patient base.

"We've got a workforce shortage, one in seven posts are currently unfilled and there is an increasing struggle to recruit dental nurses. So I think the dental sector is facing pressures from all sides and it doesn't yet have the attention of government to resolve that."

Which once again begs the question I have put previously to others, how does it get that attention?

"I think opposition MPs who have the portfolio are alive to it. I know you've spoken to Anas [Anas Sarwar MSP interview in last edition] and I think it's really helpful that he is a dentist and understands the landscape so that has really pushed this to the fore, although he no longer has the health brief he is still agitating. I think it's partly that, and partly dentists understanding they have a voice and





→ seeking out meetings with government and opposition politicians. Also talking to their patients about what is going on in the sector as well. The thing that elicits most change in politics is when constituents come to you with a concern, and if your dentist is saying 'I'm on the verge of shutting up shop here because it's no longer viable for me, please speak to your MSP about it', we will take that very seriously."

I wondered whether he felt there was also a need for direct lobbying by groups and organisations such as the BDA.

"Definitely. They're actually very good at that I think, and one of the reasons I asked the clerks in the Health

Committee for staging posts in the implementation of the OHIP was because it was a specific ask of the BDA. That was very effective because I realised, in meetings with the BDA, the depth of the profession. It's not just about check-ups, it's a whole comprehensive suite of care that's offered to patients in dental surgeries."

Disconnected

It was heartening to hear that through direct action and his roles in parliament, Alex had developed a good understanding of the importance and breadth of dentistry, but his initial lack of knowledge was once again proof that the general public really does not understand it at all. Mindful of his previous comments about

the power of the public, I asked Alex whether he thought there was any way that the profession and politicians could work together to address that lack of understanding.

"I think so. I've learnt a lot in recent months, holding this portfolio, in terms of the links I didn't understand between, say oral health and dementia in older people in care homes. The fact that, with good reason, the Scottish Government used oral health in children to understand poverty and deprivation, because there is a direct correlation.

"There is an inexorable link between oral health and a whole range of wider social issues and health issues. The health of somebody's mouth can be a barometer for a great many other things and that is why dentists are hugely important to the prevention agenda. I think it is incumbent not just on dentists but on politicians who are public-facing, to evangelise on the importance of dentistry and good oral hygiene.

"I'll give you an example of where I've been concerned. Dentists are often let down by the wider NHS as well, as there is sometimes a disconnect. I had a constituent whose dentist referred her into secondary care because of a worrying sign of early onset mouth cancer. But when the referral went into the wider NHS a letter sat in a dictaphone for two months before it was even typed up.

"This is down to antiquated systems and it is a problem across the wider NHS. These are systems that were deployed in the 1970s but not suited to the modern world. That dentist operated in good faith to say this needs to be looked into, and that didn't happen in good time. It ended well, but I think the systems and processes that wrap around the NHS don't always work."

I thought it was really pertinent that Alex was raising a perceived disconnect from his perspective of looking at healthcare in its broadest sense. It can often seem from within that dentistry is disconnected from the

rest of healthcare and the poor relation to medicine, so I asked Alex whether he felt that it was incumbent on politicians to ensure that they involve dental professionals in their wider examination of general healthcare issues such as sugar intake for example?

"Absolutely, and I think sugar is a fantastic example because we have in Scotland a very particular relationship with sugar and fat. In fact, our stats are far worse than England and Wales in terms of obesity, COPD, and other diet-induced conditions and lifestyle-induced conditions from smoking and drinking. As such I think there is an imperative for political parties to come together and have those meetings but I don't think that's happening.

"The Health Committee have had several presentations on the stubborn reluctance of these stats to drop – people are still getting fatter, kids are still getting teeth pulled at a very early age – and this is mostly because of dietary reasons, and lifestyle to a certain degree.

"We have had strategy after strategy in Scotland. We have measured oral health as



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one of the 45 national indicators from the concordat in 2007, and it is still one of them, but it's not actually making a difference. We're not changing the tide. When that happens, I think it's time to start legislating, which means rather than things being voluntary in terms of sugar reduction and re-formulation of products, they're mandatory and you cannot sell certain items with a sugar content that exceeds X or Y.

"I think there needs to be a duty on producers to make it clear on packaging what is contained within the product and I think we need to invest in alternatives and in education. While the political will is there, talk is cheap, and I say this as a liberal – I don't believe in banning things or limiting things more than is necessary, but when it is a public health emergency we need to take action."

Rudderless

Is there a role for dentistry to take the lead in this then, as no one else is? And who in dentistry instigates this and tells everyone, enough is enough, time to stop talking, time to do something?

"Yes, and that's why we absolutely need a new CDO and I'm really dismayed that we've been without one for as long as we have. Because without that then the profession is slightly rudderless in terms of its influence in government. When you have a permanent CDO you have someone who can lead the agenda, whether that's saying 'right we're going to have a particular offensive against the over use of sugar in our food and drinks' or starting public awareness campaigns.

"You can hear Catherine Calderwood, the CMO, any day of the week on the radio talking about health promotion in the wider sense, but you rarely hear anything about dentistry or oral health, and I think that's the disconnect. You need that leadership, but the CDO can also act – and this is really vital for their role – as a critical friend to government and say, 'the unintended consequences of this legislation or this strategy are that people's oral health is going to deteriorate, or at best it's not going to get any better'."

In lieu of a permanent CDO I wondered whether there was more of an imperative on the new Directors of Dentistry, who, at time of speaking were being appointed in an interim capacity, to take on some of this mantle of leadership.

"In the absence of a permanent CDO then I think they have to step up to that role, but it's whether they can get the access to the high command of government to make things happen. Often times, strategies come together across the 14 health boards, and it's a great idea, it allows cross-fertilisation of best practice and allows us to gather together the details and data of the landscape in which dentists are working, but that's just a veneer and window-dressing unless it's actually meaningful, and real change happens as a result of it. We have CEOs and chairs of health boards, and they don't have a direct line to the Cabinet Secretary, for medicine they go through the CMO, so dentistry is decapitated at the moment. That sounds a bit extreme, but without that leadership I don't have the faith that the Dental Directors will have the access to the very top of government."

As Alex had referred to the issue of many strategies, no impact, I wanted to explore his thoughts about seemingly successful strategies such as Child Smile, which has been lauded for improving oral health in the general child population but criticised for failing to close the deprivation gap it sought to address. "This is a great example of an effective strategy that has worked well in some parts of the country, but not in others. I have first-hand experience of Child Smile as I have three small children, all of whom have more awareness of their dental health than I ever

“WE ABSOLUTELY NEED A NEW CDO AND I’M REALLY DISMAYED THAT WE’VE BEEN WITHOUT ONE FOR AS LONG AS WE HAVE”



“ THE PROPOSED CHANGES TO RECALL WERE MYOPIC”

did. But that reach is to the connected population. There is a disconnected population who very sadly don't necessarily have particularly engaged parents who are there to support that understanding of oral health. They are also more likely to be exposed to high sugar and fat content meals, snacks and drinks, and, arguably, this is a blunderbuss strategy which is reaching everybody, but not getting the penetration with the people who need it most. But that is not atypical; this is the case with a lot of health-related strategies. The people who are educated, engaged and concerned will benefit, but those who are on the periphery, who face deprivation, who face multiple chaotic lifestyle factors, it will be good for the day it is delivered but it will then fall by the wayside. And that is the holy grail of public policy, how do we get sustained change in the families that need it most?”

Money matters

In that light, as Alex has already said that dentists are often the first line of reaching these groups, there must be a role for them to play in that ongoing education and outreach. Does this not call, therefore, for the strategy developers to work more closely with dental practitioners to create strategies that are achievable? One of the criticisms of the OHIP, for example, was that there was consultation but, when it came out, the profession were left with big questions about how it was actually going to be achieved. Where was the funding coming from? How was it going to be done in practice? Where is the investment to make it happen? In lieu of any commitment of funding for it, and with dental budgets continuing to be cut, how can the political world work with the profession to really push home these messages and look at what is really needed. Is the OHIP itself veneer, with lots of ‘nice to haves’ but ‘impossible to deliver’?”

“Money matters and the nomenclature of this is really interesting. If you get government talking about a ‘plan’ or a ‘framework’ I always wince because I know there's no money attached to it. If it's a ‘strategy’ then there is usually money behind it. That's where a lot of dismay from dentists came from because they felt this was virtue signalling; it is acknowledging the problems and hinting at solutions but not actually bankrolling those solutions.”

Perhaps one of the issues in getting funding for dentistry is the more overt mix between private, paid for NHS care and free NHS care in dentistry, which Alex had mentioned earlier. Do politicians, and the public, feel that dentistry doesn't need money invested into it as they think it already has lots of funds coming in through this mix?

“This is a really interesting question because it speaks to a much broader debate about the

public understanding of healthcare which is free at the point of delivery. The public believe, erroneously that when you go to your GP you're seeing an NHS employee funded by the taxpayer and it's all part of the big NHS offer. They don't understand that most GPs are private contractors. There is a huge amount of privatisation within the NHS already, we just don't see it, because we're not actually asked to hand over a credit card at the end of the consultation. That's the difference, because if you go to the dentist, even through the NHS, there will usually be something to pay and I think people see that as an aberration. That's not fair on dentists because that's the system as it's been designed, so that puts them at an immediate disadvantage in terms of public perception because there is this cynicism that dentists are in it for the money. All that is very wrong, but it is difficult to explain it to people as they are handing over their credit cards.”

Our conversation moved on in more general terms to Alex's own experiences as a patient and we started talking about how frequently we visit our GPs. Of course, this raised the inevitable spectre of the controversial action in the OHIP to increase recall times; an action which has been recently been revoked.

Or has it?

“The proposed changes to recall were myopic, they felt driven by financial sustainability rather than positive patient outcomes. That would have an impact on the morale of dentists in Scotland because first of all it suggests they're not as valued. The idea that you only need to see your dentists every 18 months to two years suggests that it's a lesser consideration, and it might also have the unintended effect of making people not take their oral health so seriously. Dentists want to do right by their patients, and they can't do an adequate job if there are big tracts of time between seeing patients because relationships are important, you need to trust



your dentist more than perhaps you do any other medical professional because, invariably, they are very intimate appointments, you are very vulnerable on their chairs. You need that atmosphere of trust and it is harder to sustain that if you have to keep asking your dentist's first name again every time you see them.

"For all those reasons I think it was a bad suggestion, but I don't think it is one that has necessarily gone away because the pressures in public policy terms mean that money will always drive things, so we have to continue to defend the frequency of appointments."

Are we looking at implementation by stealth therefore? With the OHIP's Oral Health Risk Assessments (OHRA) still in the wings is it a case of the headline being 'it's ok, we're not going to do that anymore' but an individual's OHRA suggesting it anyway?

"Absolutely. The government is constantly flying kites and testing things. This was an example of something that didn't play well but obviously they wouldn't have flown the kite, as the government doesn't like putting messages out there which are unpopular, unless there is a real reason or argument for it. There will still be hawks who are saying we really need to tighten belts and this is a definite way to do it, so I think this will be an ever-present threat now it's out there and the SNP have taken some damage for it. They don't take damage for things they're not going to pursue further down the line, so there is a definite potential risk of it being implemented by stealth."

As we all know, the recall issue first gained real public traction because of its link to oral cancer, but what about the rest of the oral cancer agenda? Is that still in people's minds, or has this headline-grabbing element pushed it off the table?

"It is a live issue and it is clear that we may have won the battle on recall but we may not have won the war. Again, this comes back to the lack of leadership in the profession and the lack of a critical friend at the top. We need a CDO to keep whispering in the ear of the Cabinet Secretary to say, we are about more than just white teeth. We are part of the comprehensive health of our patients and Scotland's citizens."

Primary issues

Since this interview, the issue around leadership and profile of dentistry seems to have worsened, as it has become clear that the Cabinet Secretary has in fact removed dentistry from her portfolio and demoted it to Joe Fitzpatrick, Minister for Public Health, Sport and Wellbeing. This is something neither Alex nor I knew at the time, but I did ask him what he saw as the primary issues for dentistry. What were the big topics that with a permanent CDO in place should be raised with politicians across the board?

"It's a broad range. Some of which we've covered. Workforce pressures, we have a diminishing pool and vacancies. Not just for dentists but for other dental professions such as dental nurses. This is largely because we've not been able to uplift the pay of dental nurses to match the changes in the living wage. There are always going to be financial issues. All of these pressures lead into pressures around dentists' own mental health. I think we often forget that the people who are delivering care are struggling themselves in many ways.

"Dentists, while they might be working in a busy city, might be isolated from peer support and might go most of your day without a meaningful conversation with another adult. That's incredibly dispiriting. A huge range of issues and, at the moment, no one is really speaking to those at the highest levels of government."





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A psychological perspective

In our modern society, peer pressure to have the perfect appearance ensures there is a constant demand for cosmetic procedures. So is it really necessary? And how do you look after the wellbeing of your patients?

WORDS
DR REBECCA CRAWFORD,
CONSULTANT CLINICAL
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The field of aesthetic procedures is now a multi-million pound industry with demand increasing every year. Societal norms and pressures regarding appearance mean that having cosmetic procedures is now viewed as mainstream and acceptable.

This demand may bring lots of opportunities for dental professionals providing aesthetic dental procedures; however, it also brings risks.

So, how do you select the right treatments and the right patients? How do you look out for the psychological wellbeing of your patients and yourself?

Question time

Remember that appropriate patient selection is just as important as technical ability in achieving an outcome that the patient is satisfied with.

Ask the person about what their concerns are..... then listen

This sounds very simple, but it is really important to listen without jumping in. Do not start any clinical assessment or discussing your opinions at this stage. Try to remain neutral and ask the patient to tell you more about their views of the problem physically and aesthetically.

Ask them to be very specific and describe their concerns in detail – keep listening and do not jump in with clinical assessment

Beware of people being vague or saying they dislike 'everything' about their teeth or appearance. We know that people are more likely to be satisfied after treatment if this has addressed what they were concerned about. Again this sounds simple, but there is a difference between this and a clinically excellent outcome as assessed by the clinician. It is essential that you elicit and understand fully what a person is bothered about in order to address this in treatment planning.

When did the person first notice the things they are concerned about now? Has this been something that they have always been aware of or has something changed recently? And When did they first become concerned about it? These are different questions!





Someone may have noticed something about their teeth for many years, but not felt that this was negative or felt the need to pursue any treatment for this. Did they become aware of it or has somebody else pointed this out or suggested they required treatment? Try to establish if the timeline for the person becoming concerned about their teeth. Again try to gather detailed information regarding what specifically is bothering them and why. Ask about any impact they feel this is having on their life and their psychological wellbeing. Make sure that they are not feeling under any external pressure from a third party to alter their appearance.

Why now? What has made the person decide to seek treatment at this point in time?

Watch out for any major life events or negative trigger events that seem to have prompted either dissatisfaction with their appearance or a decision to seek treatment. These may mean people are not in the best position to be making treatment decisions or sticking with a treatment plan at this stage.

Hopes and expectations

Ask the person what they hope will be different after treatment. This needs to be explored in terms of how they are expecting their appearance to alter, any changes to physical functioning and how they think this may impact on their life and psychological wellbeing generally.

So, now you have done all of this you can begin your clinical assessment regarding their teeth. Do this as usual.

Assessment

Before feeding back to the person about any proposed treatment consider the following points:

- Consider your clinical examination and the information you have gathered about the person's perception of the problem. Is there a discrepancy between your view and the

patient's view or are they fairly similar? Does the person have a disproportionate view of the problem?

- Beware if there is a large discrepancy between your examination and how the person views their teeth, and if their view is that their clinical presentation is much worse than your examination. As previously mentioned, we know that people are more likely to be satisfied after treatment if this has addressed what they were concerned about. However, if what they are concerned about is disproportionate and their perception is not in keeping with your physical examination, it is highly unlikely to be resolved by treatment.

- Consider the person's expectations regarding the physical and aesthetic outcomes they are hoping to achieve. Do you think these are possible and realistic now you have completed your clinical examination? If not, why not? Now think about their expectations regarding the impact that the outcome may have on their life and psychological wellbeing. Is this realistic?

Remember that there is very little robust long-term outcome data regarding the impact of aesthetic dental procedures on psychological functioning and wellbeing. Also for people with significant psychological difficulties, aesthetic dental procedures are certainly not evidence-based treatments for these. We appreciate that you are running a business, but please be honest and realistic with yourself and the patient about what can be achieved. If you get this right at the beginning people are far more likely to be satisfied at the end of treatment. With the rise in demand for aesthetic procedures comes ever increasing expectations regarding what is possible, so please be cautious with what you promise.

Next steps

How do you feel? This maybe sounds like the sort of question you might be expecting a clinical psychologist to ask a patient? But I am asking you!



IT IS OKAY TO SAY NO IF YOU DO NOT FEEL TREATMENT IS APPROPRIATE. DO NOT IGNORE YOUR INSTINCTS. IF IT FEELS RISKY OR UNCOMFORTABLE THEN NO IS PROBABLY THE RIGHT ANSWER”

Do you feel under pressure to make a decision quickly?

Do you feel pressured to offer something that you would not usually do clinically or that is out with your range of competence? Has this person been to see multiple clinicians or been to see you many times requesting treatment?

Be aware of persistence and pressure to proceed. Try to tune into this during your appointment if you feel pushed to do something, put the brakes on and consider why. Some people can make you feel very pressurised to agree to a treatment plan, this should always be a cause for concern. Treatment of this sort should be carefully considered and planned; it is never ‘an emergency’ or ‘urgent’.

Gather further information. GMPs are a fantastic source of information. If patients are complex and you have concerns, request consent to gather further information from their GP and discuss their treatment request. If people are very reluctant to agree to this – again beware – try to discuss why they might not want their case discussed; this is about their overall wellbeing, psychological and physical, so it is very important.

Consult your colleagues. If there are any aspects of a case that raise concern or you feel uncertain about, discuss things with your dental colleagues. This can also be very helpful for cases where you feel pressure to proceed; to reflect on the case with an impartial colleague can bring a different perspective and help you consider the most appropriate way forward.

Saying no! If you have gathered all of the information and considered things carefully, it is okay to say no if you do not feel treatment is appropriate. Do not ignore your instincts. If it feels risky or uncomfortable then no is probably the right answer. This may be for a variety of reasons.

Communicate clearly. Explain to the person what the proposed plan is, what this will and will not achieve functionally and aesthetically, time scale, possible risks and complications, the importance of realistic expectations regarding long-term outcome etc. Check if that is what they would like to proceed with, whether they need time to consider it and do they require further information. And if your answer to treatment is no, or not at the moment, try to communicate this sensitively but clearly and explain why, be firm about your decision and do not make any last minutes changes to this based on pressure from the patient.

Patient-centred decision

Many of these tips may seem relatively simple – that is because they are – and they should all be things that you can incorporate into routine practice.

It is also important to note that while these tips will assist with appropriate patient selection this does not replace expert psychological assessment in any way and this may be required for some complex patients.

So initial assessment might sometimes take you a little longer, you might need to consult with colleagues a bit more often, you might say no to a few people, but hopefully the patients you do select will reach a collaborative, patient-centred decision with you, be satisfied with what you achieve, and your own psychological wellbeing will remain intact.





What are the clinical implications of a patient's desire to 'look perfect'?

Case A

PATIENT A attends for an initial assessment appointment with you. On first impressions you feel that their presenting problem is in the mild range. You use all of your new skills – as detailed on the previous pages!

The person explains to you that they feel their problem is very severe and worse than anyone else they have ever met. They are very vague about what specifically concerns them but 'hate everything about their teeth' and would like you to 'just sort it out' so that their teeth look 'perfect'.

They explain that they have been concerned about their teeth for many years but have decided to pursue treatment now as they feel worse about their teeth; however, they are unclear about why and mention that the appearance of their teeth has not changed. They hope that you will be able to make them 'beautiful' and that they will feel happier and more confident as a result. They feel their whole life will be different, in a positive way, if their teeth were altered.

They also mention that they have already a number of other clinicians about this, but all of them have declined treatment. The person feels this is because these clinicians do not really understand their concerns properly, and they are hoping that you will be able to because they are not sure what they will do next if you decline treatment too. They are very keen for you to make a decision today, as they do not have time to waste and will need to see someone else if you are not willing to do it.

Consider all of your points – what would you do?

Disproportionate concern, which is vague and out of line with your clinical examination. Unrealistic expectations of what any treatment will achieve physically and psychologically. Persistence and pressure to proceed. All of these points are leading you to conclude that treatment is not indicated. Although the presenting problem may seem mild from a physical point of view with a simple low-risk solution, managing the psychological aspects of this case mean that it is likely to be complicated with a high risk of the person being dissatisfied with the end result.



THEY HOPE THAT YOU WILL BE ABLE TO MAKE THEM 'BEAUTIFUL' AND THAT THEY WILL FEEL HAPPIER AND MORE CONFIDENT

Case B

Patient B attends for an initial assessment appointment with you. On first impressions you feel that the presenting problem is in the moderate to severe range. You use all of your new skills – as detailed above!

The person explains to you that they feel their problem is quite bad. They are specific about what concerns them and have brought a list with details about this, and the impact they feel teeth are having on life. They explain that they have become increasingly concerned about their teeth in the last few years but have decided to pursue treatment now as they have the financial means to do so. They hope that you will be able to discuss some treatment options for them to consider, but are happy to go with whatever you think is best.

During the assessment the person is very agitated, finding it difficult to make eye contact, and struggles to articulate all of their concerns to you. They mention that they find it very difficult to meet new people and have been very worried about coming to their appointment today. They have prepared by writing things down and taking their medication, as recommended by their GP. They are hoping that treatment for their teeth will improve their confidence and self-esteem and make them less self-conscious about their appearance.

They also mention that they were previously very concerned about the appearance of their nose and have had cosmetic surgery privately. They feel that this did address their concerns about the appearance of their nose. They acknowledge that this did not have the broader impact on confidence and social functioning that they were hoping for.

Consider all of your points – what would you do?

Unrealistic expectations of what treatment may achieve from a psychological perspective. Previous cosmetic surgery which has met physical but not psychological expectations. Overt signs of anxiety at assessment. Mention of medication and GP awareness of these difficulties. All of these points may lead to you to feel that you require further information about this patient and to discuss the case with the GP. If the person has significant difficulties with anxiety these will not be resolved by having dental treatment. Although the presenting problem is moderate to severe from a physical point of view, do not let this cloud your judgement or discount the psychological aspects at play here. Managing the psychological aspects of this case and considering these in any suggested treatment plan are essential in reaching a collaborative plan, at the right time, with realistic goals for outcome psychologically and physically.

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Patient protection project proves a knock-out

A trio of dental core trainees have been working with students and sports teams to improve outcomes following dental trauma



Three dental core trainees in Glasgow have launched an initiative to improve awareness of the action people should take if they or a teammate suffers dental trauma such as tooth avulsion.

The trainees – Victoria Cave, Emma O'Donnell, and Niamh McGrath – were moved to take the action, proposed by Victoria, after encountering the complications of dental trauma in maxillofacial, restorative and oral surgery. Naming their project *It's a Knock Out*, they have received support from Beth Burns, Consultant in Restorative Dentistry and Scottish national representative of Dental Trauma UK. Emma explained: "The project has been on the go for six months. It was meant to be small scale, but has grown arms and legs.

"We started noticing that people were getting teeth knocked out and no one around them knew what to do. We would see them days down the line when there was no hope of the tooth lasting long term. We thought if we could get to those who are likely to be on hand we would eventually be able to improve outcomes."

She pointed out that brief research into the topic throws up some eye-opening statistics. By 14 years of age, 30 per cent of children have experienced a dental injury. Sports-related accidents account for 10-39 per cent of all dental injuries.

Wearing a properly fitted mouthguard during high-risk sports has been shown to reduce significantly the risk of dental injury. However, for many high-risk sports in the United Kingdom, using a mouthguard is not compulsory. As a result, participants are at significant risk of traumatic dental injury.

Victoria said: "If that does occur it often results in someone requiring multiple appointments over years, missing many days of work or school. And it represents a significant cost burden to the patient and the NHS – the average total cost of treating one patient with one traumatic injury has been cited as £856."

Critical

It's known that immediate management of avulsion injuries is critical for improved outcomes. A delay or inappropriate emergency treatment can cause long-term complications and affect tooth prognosis as well as the patient's quality of life. Traumatic dental injuries most often involve the anterior maxillary teeth and can have a significant effect on dental and facial aesthetics. The significant consequences of dental trauma include crown discolouration, pulp necrosis, pulp canal obliteration, inflammatory root resorption either internal or external, ankylosis and aesthetic concerns. Avulsion leads to the greatest functional and aesthetic impairment due to its poor prognosis.

WORDS
STEWART
MCROBERT



“

WE STARTED NOTICING THAT PEOPLE WERE GETTING TEETH KNOCKED OUT AND NO ONE AROUND THEM KNEW WHAT TO DO. WE THOUGHT IF WE COULD GET TO THOSE WHO ARE LIKELY TO BE ON HAND WE WOULD BE ABLE TO IMPROVE OUTCOMES”





Most traumatic dental injuries in school-aged children occur at home or at school. Periodontal ligament cells become non-viable within 60 minutes, and to avoid damage to these cells the tooth must be either placed back in the socket, or in an appropriate storage medium (milk, Hanks' balanced salt solution or saliva) within four minutes. The action of the first responder to an avulsion is therefore critical.

Niamh added: "Our aim was simple; to reduce the risk of dental trauma and improve outcome following avulsion injury by providing education on prevention and management of dental trauma in higher-risk groups."

This project is being aimed at Higher physical education and sports leadership students in Glasgow high schools, managers of local sports teams, and Scout and Girlguiding leaders. "We also want to encourage dentists to engage with their patients and local communities on prevention and immediate management of an avulsion injury," said Niamh.

When the trainees contacted high schools, sports hubs, and Scout/Girlguiding groups in Greater Glasgow, the response was overwhelmingly positive. Victoria explained: "We arranged 30-minute workshops where we targeted those who were deemed high risk, with our main focus being on the importance of preventing dental trauma.

"We provided 'before and after' questionnaires to gather the initial level of knowledge around avulsion. There were a variety of answers regarding how to store an avulsed tooth; in water, milk, tinfoil, the fridge and one vote for under your pillow!"

Meanwhile, many of those asked before the workshops said that accident and emergency was the most appropriate place to attend after having a tooth knocked out. This is borne out in research. Approximately one-third of patients present to an A&E department when first seeking medical help after a traumatic dental injury.

However, the best course of action is always to attend a dentist as soon as possible. Alternatively, if it's out of hours or they are not registered patients can phone NHS24

who will direct them to an emergency dentist close by. Similarly, if the local A&E department is in a hospital with a maxillofacial unit there may be dentists on site who know to re-implant the tooth quickly.

Niamh explained: "Meanwhile, it's well documented that on-time and appropriate treatment, alongside clinical and radiographic follow-up, is important to lessen the effect of traumatic dental injuries and prevent complications."

Custom made

Those attending the workshops were involved in coaching, dance, martial arts, Gaelic football, rugby and football. Participants in contact sports such as rugby and Gaelic football recognised the need for mouthguards and some used them regularly. However, those taking part in sports such as football said they would never think of wearing a mouthguard – it isn't the done thing and they think there's no need to do so. The session covered the benefits of wearing a mouthguard, particularly one that's custom made. Compared to the 'boil and bite' type, custom-made mouthguards are less likely to dislodge on impact, and provide more uniform material thickness as well as improved cushioning. They may reduce the risk of injury to TMJ and it has even been suggested that they reduce concussion risk

There was also a short presentation, including videos from Dental Trauma UK, showing how to replace an avulsed tooth at the time of injury. The workshop content covered prevention, mouthguards, dental caries associated with sports drinks and Dental Trauma UK's Pick It – Lick It – Stick It campaign, which includes posters and pitch-side how-to sheets for first aid boxes.

A practical element allowed participants to re-plant an avulsed 'tooth' on dental models. To conclude, there was information on other dental injuries including those that should be seen by A&E, such as fractured jaw and loss of consciousness, as well as those that don't need immediate management, like tooth fractures, intrusions and luxations

After the workshop the questionnaire was distributed

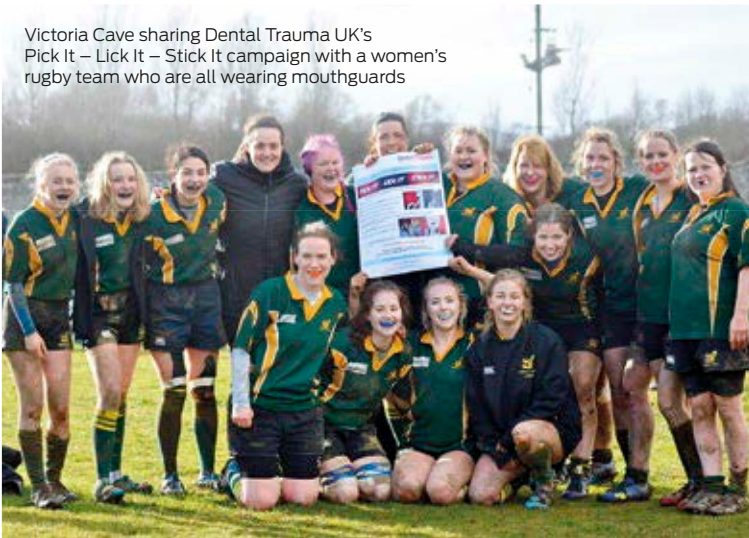


OUR AIM WAS SIMPLE: TO REDUCE THE RISK OF DENTAL TRAUMA AND IMPROVE OUTCOME AVULSION INJURY BY PROVIDING EDUCATION ON PREVENTION AND MANAGEMENT OF TRAUMA IN HIGHER-RISK GROUPS



L-R Victoria Cave, Emma O'Donnell, Mrs Beth Burns and Niamh McGrath

Victoria Cave sharing Dental Trauma UK's Pick It – Lick It – Stick It campaign with a women's rugby team who are all wearing mouthguards



30%

of children by the age of 14 have experienced a dental injury

Sports-related accidents account for

10-39%

of all dental injuries



again. The results revealed an increase in participants' knowledge and greater readiness to deal with a dental avulsion.

"So far, we have held approximately 10 workshops," said Emma. "The numbers attending depend on the location of the workshop. In the cases of schools we can have an average of 40 students coming along, and in the case of rugby we often address two team before a match and have a quick workshop afterwards, so there are upwards of 30 people there."

However, the workshops have not been the only activities. The trainees have contacted other local sport teams and put them in touch with local dentists who are able to provide mouthguards.

Now that the first phase of workshops have taken place there are plans to visit more Glasgow schools. There has been some success in spreading the message. Fellow trainees with family in Aberdeen and Northern Ireland have begun replicating parts of the project in those parts of the world. Dental Trauma UK is also working on recruiting dentists to regional representative positions all over the UK to ensure the message is wide-reaching.

Education

Unfortunately, the acute management of dental trauma is rarely taught in first aid training courses and barely appears in first aid manuals and books. "That's why we are encouraging dentists join Dental Trauma UK," said Emma. "They can use the excellent education resources available, and be active participants in their local communities."

"Dentists should consider providing aid to local sporting teams to make sure they know what to do in these emergencies. They can signpost sports clubs and patients to guidance and how-to leaflets like those available through Dental Trauma UK*."

"Equally, it would be beneficial if dentists were to promote a 'no mouthguard no play' rule for contact sports."

She and her fellow trainees believe this sort of action can be a practice builder. And they are encouraging dentists to promote prevention by supplying custom-fit mouthguards, as well as including a question on participation in high risk sports and mouthguard use on medical history forms.

Emma concluded: There's no doubt if we work together, we can improve dental trauma outcomes for all of our patients."

*Resources available at www.dentaltrauma.co.uk

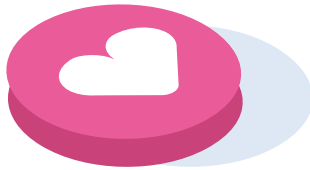


SO FAR, WE HAVE HELD APPROXIMATELY 10 WORKSHOPS. IN SCHOOLS WE CAN HAVE AN AVERAGE OF 40 STUDENTS COMING ALONG, AND IN THE CASE OF RUGBY WE OFTEN ADDRESS TWO TEAMS BEFORE A MATCH AND HAVE A QUICK WORKSHOP AFTERWARDS"



Social media — a blessing or a curse?

WORDS
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The world has rapidly transformed into a highly technological place, and the field of dentistry has been significantly and largely positively affected by this revolution. Social media can be a powerful and effective tool for dental professionals, but there needs to be an appreciation of the potential risks when using an online platform.

Social media encourages a collaborative approach to education with the intention of improving engagement with patients and stakeholders, and it can be used for promotion or brand messaging. However, the risks of social media cannot be ignored. Hazards to be wary of include misinformation, negative feedback, indiscretion and breach of confidentiality, stalking or trolling as well as defamation.

Misinformation

The internet has irreversibly changed the way people access data and information. Knowledge can be 'pulled' instantly from a device in your pocket and answers can be found to most questions. Social media allows information to be 'pushed' even more easily on many different platforms.



Philip Johnstone

A survey exploring the ways in which the public finds out about orthodontic treatment found that nearly three in four respondents (71 per cent) would rely on the internet while just over one in three respondents (35 per cent) will have a discussion with their dentist.¹ The internet certainly holds useful and important information regarding orthodontic treatment but it cannot replace a discussion about an individual's unique clinical circumstances with an appropriately trained clinician.

Breach of confidentiality

Dental professionals have a duty of confidentiality to their patients. The GDC states that dental professionals must not post information or any comments about patients on social network sites. Clinicians are able to share anonymised cases that illustrate discussions relating to best practice but must be extremely careful that the patients can never be identified.

It is very important that dental registrants are always aware of this principle when using any social network, even if it is to communicate with colleagues. Advice

to dental professionals is never to publish any information about patients on social media unless they have explicit consent.





Negative feedback

Social media is an attractive tool to promote a dental practice or offer dental services. However, it also potentially exposes dental professionals and businesses to unwelcome and sometimes undeserved negative feedback. In fact, patients – real or trolls – are actively invited by several agencies to review the care that a practice or clinician provides and it can be very difficult for dental professionals to manage negative feedback.

Dento-legal organisations receive many calls from dental professionals who ask for advice about responding in these circumstances. Questions include whether to reply to the negative comments on the same social media platform or whether to contact the patient directly.

Advisers are frequently asked if other members of staff can post positive reviews to defend the reputation of the practice or a clinician.

The advice is that a dentist should never respond to patient's complaint directly on line because of the duty of confidentiality. Rebutting an online complaint by a reciprocal posting is also fraught with the risk that it develops into a public spat. The GDC's Standard 9.1.3 states that dental professionals "must not make personal, inaccurate or derogatory comments

about patients or colleagues" on public media. It clarifies that "public media includes social networking sites, blogs and other social media."²

The GDC may consider that a registrant who posts fake reviews of their practice on social networks or encourages team members to do so is behaving dishonestly. If found proven that the registrant is posting fake reviews, the GDC is likely to apply severe sanctions.

It is, in any case, better and more effective to ask satisfied patients to post reviews.

Stalking and trolling

The line between personal and professional use of social media can often be unclear. It is commonly accepted that there is no such thing as a 'private' forum on social media.

Dental registrants and other team members must ensure that their behaviour on social media is professional at all times. The GDC in Standard 9.1 tells registrants: you "must ensure that your conduct, both at work and in your personal life, justifies patients' trust in you and the public trust in the dental profession".³

Dental professionals should stop and think before posting a comment in any forum even if, on the face of it, the post will only be read by a few people known to the poster. Ultimately, it must be assumed that any comment can be passed on, accessed and read by anyone.

Maintaining professional boundaries with patients in a world in which social media is an easy and swift way to communicate can be a tricky balancing act. Informality, however, lends itself to unintended challenges to professionalism. It is also advised that a clinician should not 'friend' their patients on social media networks. Even if the professional relationship appears to be nonthreatening at the time, the risk of subsequent stalking or trolling by the patient must be appreciated.

Your indemnity organisation will offer guidance on the benefits, risks and considerations of communicating via social media. The General Dental Council also publishes helpful advice on its website.

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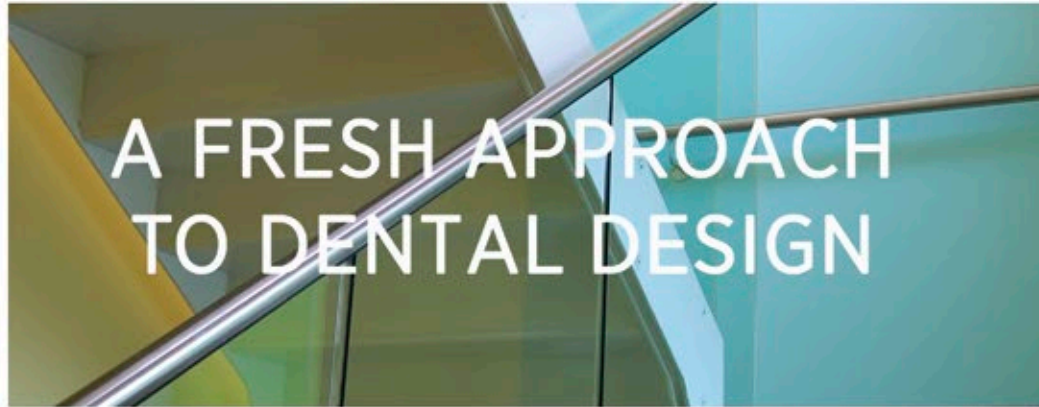
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Use of stainless steel crowns in the permanent dentition of paediatric dental patients: A guide for GDPs

Scott J F Wright, Dental Core Trainee, Glasgow Dental Hospital & School



ABSTRACT

The use of preformed metal crowns (PMCs) or stainless steel crowns (SSCs) within paediatric dentistry is widely accepted. Predominantly, this is for the treatment of carious primary molars. This article aims to increase readers' awareness of the use of PMCs for permanent molars in a paediatric population.

Introduction and background

The majority of treatment of paediatric patients in the UK is carried out by general dental practitioners. It is therefore crucial that GDPs are aware of treatment options for these patients.

Preformed metal crowns (PMCs) were first described by Engel in the 1950s¹. Primarily, their use has been for the restoration of primary molars that have caries or structural defects. There is a large and growing body of evidence to suggest that primary teeth restored with PMCs are less likely to develop problems or cause pain in the long term than those primary teeth restored with conventional restorations.² Teeth that were restored using the Hall Technique were also shown to give less discomfort at the time of placement than conventional restorations.² There is wide acceptance of this technique to restore primary molars in both the United States and United Kingdom.^{3,4}

There is less evidence and information surrounding the use of PMCs for permanent molars, but they can be a useful addition to the armamentarium of any dentist treating paediatric patients. Permanent molars of poor prognosis can interfere with eating, sleeping, attending school, and taking part in daily activities.^{8,9,10} Children can experience pain and infection, as well as a reduction in their overall quality

of life.^{9,10} Additionally, retention of permanent molars of poor long-term prognosis can be beneficial orthodontically. RCS England guidelines suggest that the ideal time for extraction of first permanent molars is between eight and 10 years old.¹³ PMCs can be helpful in assisting with this and prolong the retention of molars that would otherwise be lost.

Dean et. al⁵ found that about 48 per cent of Scottish GDPs assessed in their study were already using PMCs with the Hall Technique for the management of caries in primary molars. Anecdotally, however, there is limited knowledge of GDPs surrounding the use of PMCs in the permanent dentition.

As mentioned above, there is a comparative limited body of evidence to support use of SSCs in permanent molars to that of primary molars. In 2016, a study in the US suggested that use of permanent tooth SSCs as an interim restoration resulted in an 88 per cent success rate, with an average lifespan of 45.18 months in all age groups. This result was statistically significant in the under-nine age group (P=0.001). However, this was a small sample size.

PMCs are valuable in the interim management poor prognosis permanent molars. This article aims to give GDPs an introduction to the use of PMCs in the permanent dentition for paediatric patients. Many of the principles and skills used

in restoration of primary molars with PMCs can be applied to permanent teeth.

Indications for use of PMCs in permanent molars

There are many clinical circumstances in which PMCs for permanent molars can be a useful treatment choice. Paediatric patients can present with difficult clinical scenarios that require operative intervention due to caries or structural defects in these teeth. This can be further complicated by social factors including parental or guardian wishes, child anxiety and medical history.

- Multi-surface caries in permanent molars where use of composite or amalgam is contra-indicated
- Pre-co-operative or anxious child precludes conventional restoration
- Structural defects such as molar-incisor hypomineralisation, amelogenesis imperfecta, dentinogenesis imperfecta
- Temporary restoration until definitive treatment accepted such as extraction for orthodontic purposes.

Of benefit is the limitation to caries progression and reduction in symptoms that can be achieved through use of PMCs.

Contraindications for use of PMCs in permanent molars

There are relatively few contraindications to the above.



Permanent Tooth PMCs and Orthodontic Separators

However, below are some aspects that require consideration.

- Nickel allergy – stainless steel crowns is in fact a misnomer as PMCs are constructed with nickel chromium
- Insufficient tooth structure to retain crown
- Signs or symptoms of irreversible pulpitis
- Peri-apical pathology.

Technique for placement of PMCs in permanent molars^{2, 11, 12}

The technique for placement of PMCs in permanent molars is very much dependent on compliance of the child patient. Many previous articles advocate the use of conventional preparations however, the use of a modified 'Hall Technique' approach can also be used.

Pre-treatment preparation

- Explain the treatment to patient and guardian, obtaining informed consent.
- Place orthodontic separators, using two lengths of floss, three to five days before scheduled appointment for fit of PMC
- Rehearse procedure with patient and guardian.

Treatment appointment – Placement

- Gauge initial size of PMC required by measuring mesio-distal distance of tooth and choosing the most

appropriately sized crown

- Conduct minimal preparation including slight mesial-distal and minor occlusal reduction if appropriate or clinically possible, not required in all instances
- Remove caries with excavator or handpiece if appropriate or clinically possible, not required in all instances
- Adjust height of crown using crown scissors, the PMC should extend just to the ACJ of the tooth where possible, and slightly subgingivally (Figures 1a, 1b, 1c)
- Smooth rough edges with a polishing stone or disc
- Adjust margins of PMC with crimping or other orthodontic pliers to ensure a secure fit of the PMC cervically around the tooth (Figure 2)
- Practice seating of PMC with child after showing them the crown
- Sit the patient upright and protect the airway with gauze
- Isolate the tooth being treated appropriately to minimise moisture contamination
- Fill the adjusted PMC with resin-modified glass ionomer cement and seat firmly with thumb pressure, placing a cotton-wool roll occlusally
- Ensure the PMC is in the correct position and encourage the child to bite firmly onto the cotton wool roll, continually assessing the position of the PMC. Gamification in the form of asking the patient to play 'tug of war' or 'biting down like a tiger' can be helpful at this time while you 'attempt

to remove' the cotton-wool roll.

Treatment appointment – Post-placement

- Remove excess cement with probe, excavator and knotted floss interproximally.
- Check final position, occlusion and gingival condition, gingival blanching is normal
- Give post-operative instructions, positive reinforcement and reward with a sticker.

Post-operative instructions

Post-operative instructions can be given that are very similar to those given when placing PMCs on primary teeth. Advise parents and children that occlusion will be slightly high but will settle within three to five days. Analgesia may be required, and paracetamol and ibuprofen, if not contraindicated, would be appropriate. Asking parents to reinforce positive messages between appointments is of benefit to developing co-operation, particularly if multiple PMCs are being placed.

Complications and troubleshooting

Complications can occur with all treatment and therefore it is key to ensure that after placement, PMCs are monitored clinically and radiographically to assess for signs of success and failure.

During placement, if the crown is





Figure 1a Use of crown scissors to adjust the height of PMC



Figure 1b Further adjustment of height of PMC

deemed to be in the wrong position, it may be possible to remove it with an excavator before the cement sets. If this is not possible, removal can be performed by cutting a slot buccolingually across the occlusal surface of the crown, and extending this down the buccal aspect. The crown can then be peeled away using an excavator.

Adapting the margins of PMCs on permanent molars is crucial. Failure to do so may result in secondary caries, periodontal disease or impaction of unerupted teeth.^{5,11} The margins should sit tightly around

the neck of the tooth to reduce the aggregation of plaque leading to the development of carious lesions or periodontal disease. Assessment clinically using a sharp probe, floss and bitewing radiographs should be conducted to determine success.

Conclusion

To conclude, the use of PMCs in paediatric patients should not simply be limited to primary teeth. PMC placement in permanent molars for a paediatric population should be part of the skillset of all GDPs in order to best manage clinical scenarios

without the need for referral to specialist services. Development of this aspect of paediatric dentistry can only come with education and practice; the authors hope that this article can assist with this.

SCOTT J F WRIGHT

The author wishes to express grateful thanks to Mrs Christine Park, Honorary Consultant in Paediatric Dentistry, Glasgow Dental Hospital & School, University of Glasgow.



Figure 1c PMC, adjusted for height, with excess material that should be disposed of in Sharps waste. Margins should then be adjusted.

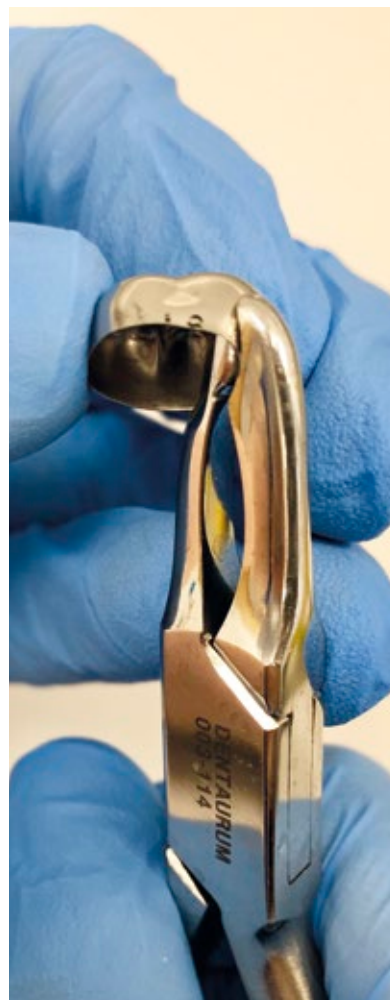


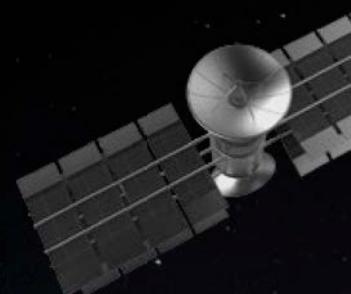
Figure 2 Crimping of PMC margins following adjustment of height

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HOW DO WE KEEP OUR PATIENTS HAPPY?

That's the \$64,000 question as each individual's needs and expectations will be different ... and it's our job to meet them

[WORDS: SUSIE ANDERSON SHARKEY]

SO MANY ARTICLES, EVEN WHOLE books, have been written on wide-ranging subject of patient satisfaction that in this article I'm outlining just a couple of things I've learned from experience over the years.

No matter whether the patient is old or young, NHS or private, there are standards which are the same right across the board. There is a level of courteousness, efficiency and professionalism that is expected in the industry, whether that be from a dentist, hygienist, nurse or receptionist.

The patient perspective won't just begin when they walk through the door of the practice. They will have formed opinions even before they get there. If spoken to on the phone, was the receptionist polite? Was the receptionist able to answer any queries the patient may have had, and if not, did he/she ensure that they were put in contact with the person that could help them? If a patient has been contacted by social media, how long did they have to wait for a reply? If by email, once again was it dealt with promptly?

Different people have different expectations but how do you go about ensuring that you exceed those expectations each and every time the patient is in the surgery? OK, so I think it's fairly safe to say that there are some people, no matter how much you do for them, they will just never be happy. But thankfully those patients are few and far between, and by and large if we present an outstanding service, the patients will be outstandingly grateful.

Firstly you must show genuine interest in your patient. They will soon pick up if all you're interested in is getting them in and out of the door as fast as possible. A few moments of chat each visit, building rapport, building a relationship with the patient goes a long way in securing patient loyalty for years to come. Sometimes the patient just wants a few minutes to chat about what's happening in their life, and if someone in the

practice takes some time to lend a listening ear they will know that you genuinely care about them. May I quote that well used but very true saying "People don't care how much you know until they know how much you care".

A few months ago I happened to be at the main reception desk when a patient came out from one of the surgeries and was about to pay a considerable amount of money. His phone rang and he had to take it, walked away from the desk, spoke to someone for a minute or two then came back to the desk absolutely choked up and hardly able to speak...his mother had just that moment died. I took him away from the reception desk, sat him in my office, made him a cup of tea and told him to take as long as he needed...the money could wait.

What that man needed at that point was a bit of space to grieve, a quiet place to sit and take in the news that had just been delivered

to him. He didn't need us at that precise moment asking him to pay a substantial bill and make his next appointment. I gave him his tea, time and space to be on his own and then told him to get in touch with us later.

A little compassion goes a long way.

Secondly we must listen. What is the patient really saying to us? It may not be what we expect them to say (or even want them to say), and it's so important we don't have pre-conceived ideas of what the patient thinks. And very often what the patient doesn't say is as important as what they do say and without taking time to listen then we make

assumptions that are way off the mark.

Many years ago I had exceptional customer service and it's my gold standard that I went back to time and again when I was practice manager. (I've recently stepped down as practice manager and am now working as a treatment co-ordinator).

In my new role as treatment co-ordinator it is my aim to give every single patient as much time as they want or need. If they want to chat about any aspect of their treatment, I will be at the other end of a phone for them and I want to ensure that they feel totally connected to us and that we are in this patient journey together.

I want to hear what the patient expects from us and then I want to ensure that we absolutely surpass that expectation every step of the way.

So to summarise: Courtesy, professionalism and efficiency are just the starting point. Listen, take some time with each patient, find out what they expect ... and then do far more.



“
IT'S IMPORTANT WE DON'T ASSUME WHAT THEY THINK. VERY OFTEN WHAT THE PATIENT DOESN'T SAY IS AS IMPORTANT AS WHAT THEY DO SAY”

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

A SIMPLER APPROACH CAN PAY DIVIDENDS

Encouraging patients to take control of their own dental health might not be a popular move among some people, but it will pay off in the long run

[WORDS: ALUN K REES]

IN HIS FINAL LECTURE BEFORE OUR

graduation in 1978, the Dean of Dentistry in Newcastle, Professor Roy Storer, waxed lyrical about our futures. Many of us listened through a slightly hungover haze as our post-finals results celebrations were ongoing. I do remember well that he made a couple of points relating to changes that he foresaw. First, that we would be dealing with an ageing population, and second, that we must learn to embrace teamwork.

I filed those away, and, anxious to get out into the big world and on with my life, I didn't really consider them again for several years.

As a student the only consideration of ageing I had been taught was preparing patients for dentures. At the time I thought I didn't want to wear dentures so why would anybody else? Manpower considerations, limited public expectations and an overwhelming amount of disease meant that in many cases wholesale extractions and dentures were the only option offered.

I vowed that dentures would be the very last resort for my patients, and so conservation led the first decade of my clinical career.

Sadly nothing lasts forever. Restoring a patient's mouth without ensuring they could maintain it themselves often led to early failure and sometimes more complications that could possibly have been avoided. Certainly there were times when my hopes were unrealistic.

Having spent many hours restoring a mouth with crowns and bridges I watched as the habits that led to the initial need for complex restorations reasserted themselves and my "clever" dentistry also failed. Sometimes I believe that I may have left patients worse off.

By the time I was ready to be my own boss, with my own practice, four decades had passed since the start of the NHS in the UK. Throughout the world, attitudes and expectations were changing, albeit at different rates. I decided that I must put prevention at the absolute core of everything that I did and I swapped the order around, putting prevention before restoration. Until patients could control the diseases in their mouths, until they could realise that the only way that they could get off the cycle of decay and restoration was for them to take control I would not embark on major treatment plans. Some patients didn't like my philosophy and sought care elsewhere; at first that hurt, but later, it helped me to sleep more soundly.

My studies with Mike Wise helped me to see that everything, even what appeared to be complex cases, should be done as simply as possible but, as Einstein said, no simpler. The effect on my dentistry, both clinical and organisational, was profound. For every step there needed to be a straightforward way of reversing, so that no large treatment plan, or indeed part of the organisation, was dependent on one element.



During the 80s and 90s patients were being told that crowns and bridges would “sort everything out” and they wouldn’t have any more problems. As those patients aged and things started to fail the answer was implants, which were, and are, fantastic, but they can also have drawbacks when they are not maintained.

The beauty of the simplicity approach reflected itself as Roy Storer’s wise words started to come true. I saw an increase in dental disasters where large numbers of restorations were reliant on, for instance, a root treated, post retained, abutment or where occlusion had led to excess loading.

To return to the other element of Roy’s prophecy about teamwork. From day one in my own business, I delegated as much as I possibly could. Firstly to nurses who were all trained in delivering listening to patients, delivering oral hygiene advice and explaining treatment options. Then we were joined by a full-time hygienist, which raised a few eyebrows as I was the only dentist in the practice and at the time did not have a full “book”.

Paradoxically, having the team with expanded roles to whom I delegated as much as I could meant that I got busier. Because I was doing what only I could do, I also became more profitable.

When the time came to remove our reliance on the NHS for adult provision we were well placed and the transition went smoothly. Having shifted the focus from

reacting to disease and breakages to being proactive and planning our patient care for the long-term there was far less resistance from patients who might eventually need extensive, and expensive, care. The vast majority knew what was best for them and often asked me, “is it time yet?”.

I’m not going to suggest that all was a bed of roses; life, and particularly dental life, is not like that. Maintaining a happy team that gradually evolves is challenging but rewarding. Not every patient turns out to be compliant in the long term, some patients arrive with catastrophic dentitions and immediate intervention was required before the patient and I had got to know each other’s outlook and expectations.

I still share my philosophy of practice with my clients and have helped many embrace changes for their own success.

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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“
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THAT I MUST PUT
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EVERYTHING I DID”**

OUTSOURCE, AUTOMATE, DELEGATE



Is your practice management properly organised?

[WORDS: RICHARD PEARCE]

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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DOES THIS SOUND LIKE YOU?

You receive texts from 6.30am from nurses telling you they are sick and can't work today.

When the suction breaks, you get called, even when you are out collecting the children from school.

Sales people appear in the appointment book for 'lunch and learn' just when you were looking forward to a free lunch break.

When popping to the loo, you get stopped by a nurse asking if they can take a holiday... next week.

You don't really know how well the practice is doing. What's in the bank account seems to allow you to take out enough to afford a lifestyle that is sort of OK.

You hate paying invoices! You get handed a stack of them, which gets added to during the month.

When you pass reception you occasionally wince when you hear a nurse on reception. She's trying to be helpful but doesn't know how much a crown is and has no idea how to sign up a patient for the plan.

C2 composite has run out again. You know this because while seeing a patient, a nurse from another surgery has come in and is whispering to your nurse and they are rummaging through drawers.

You chat to an associate as you are heading out the door. They're unhappy about the number of new patients they are seeing but don't know how many it actually was last month.

You get interrupted every other week with a brilliant advertising offer from the local paper. You tell them that you're not interested at the moment, kidding yourself that it is not in the current marketing plan. Having a marketing plan... That's a laugh!

You refuse to look at the practice website because it annoys you every time you check it. It's old, lots of information is wrong and you're not even sure anyone looks at it anyway.

A fuse keeps going in Surgery 2, but someone presses 'Reset' and struggles on.

On the drive home you think to yourself, "I guess this is what being a practice principal is like!"

You live with a constant, underlying feeling of not being in control and wondering where the next 'disaster' will come from.

But, come on! This is no fun. You really enjoy seeing patients, but the rest of it is just a chore. So how can you get organised and free yourself from this tyranny?

OUTSOURCE, AUTOMATE, DELEGATE

• **Outsource** – Employ a third-party company or individual to manage this task/service.

• **Automate** – Use an online or digital system.

• **Delegate** – Give this task to a staff member who clearly understands the outcome required, how the task is to be completed and how they report on its progress and results.

Only after you have exhausted all three of these possibilities should you consider doing the task yourself.

Let's look at how we DELEGATE first, by starting with the practice manager.

When was the last time you reviewed their job description and confirmed that they do manage all the tasks that are detailed there? Should some of the tasks that you currently do be added to the job description and then you train, monitor and inspect how those tasks are now being completed?

Does the practice manager 'own' the practice operations manual, which details every procedure that happens in the practice? Here is a tiny snapshot of what should be included in it:

- materials ordering
- signing up patients to the membership plan
- daily cash-up
- list of preferred tradesmen with contact numbers (examples are given for who deals with what issue)
- invoice management
- monthly management reporting
- float maintenance
- sales rep booking-in (it's when you want it, not when they happen to be passing).

You might also consider having a separate reception manual, which details procedures specific to front of house.

The staff handbook should cover everything that is related to staff, such as a procedure for requesting holidays.

The PM can also delegate but they might need to be trained on how to train, monitor and inspect effectively.



YOU LIVE WITH A CONSTANT, UNDERLYING FEELING OF NOT BEING IN CONTROL AND WONDERING WHERE THE NEXT 'DISASTER' WILL COME FROM

Now let's AUTOMATE what we can.

• Staff can clock-in with a card clock-in system or app-based system such as Rotacloud, which can also be linked to a payroll system.

• Xero or Quickbooks has invoices scanned to it (Autoentry) and automatically syncs with practice bank accounts. The rules set up mean that assigning income and expenses is a 10-minute per month job, which could be delegated to the PM. So now we have a monthly P & L.

• We know our 'base' materials requirement every month – we order online, once a month. Some items are cheaper if bulk ordered every three months and we have storage space.

• Staff request holidays (and it is authorised) using an online system (Rotacloud again), but there are others.

• As many suppliers as possible are paid by direct debit. We don't do cash or cheques. Invoices have to be sent by PDF, this is the 21st century after all (paperless office!)

Finally, OUTSOURCE. A larger practice might consider a bookkeeper coming in one or two times per month to manage this function. They can also prepare forecasts (and provide variance analysis) run payroll and aged debtor reports etc.

Digital marketing, graphic design and web design are outsourced to a specialist agency. You meet with them monthly or quarterly to review the plan and results.

Practices can bury themselves in the weeds and so fail to focus on the big picture. It takes real discipline to take two steps back and analyse what's actually happening. It then takes energy and maybe some investment to change.

MDDUS CASE STUDY:

INSTRUMENT FAILURE

DAY ONE

Mr Z attends the dental surgery of Ms J complaining of pain in a lower right tooth, 46. Mr Z advises Ms J that it is particularly painful when biting and chewing. Ms J notes that this tooth had been restored two years' previous. Ms J carries out a detailed extra-oral and intra-oral examination, concentrating on 46. Following this examination and the taking of and review of appropriate radiographs, a diagnosis of irreversible pulpitis is made. Ms J discusses the treatment options with M Z, including root canal treatment or extraction. Mr Z opts for root canal treatment and an appointment is made for two weeks' time. Ms J prescribes an antibiotic, aiming to reduce infection and ease Mr Z's pain.

DAY 14

Mr Z attends for the first visit of root canal treatment of 46. Ms J takes a further pre-treatment radiograph. Appropriate local anaesthetic is administered by her. Ms J proceeds to remove the existing restoration, accessing the pulp chamber and root canal system, removing the necrotic pulp using a barbed brooch. Ms J next employs a lentulo spiral filler to spin Ledermix into the root canals. Unfortunately this instrument fractures and part of it is retained in one of the root canals. Ms J uses another spiral filler to try to remove the lodged fragment, but is unsuccessful in her attempts. Ms J abandons the procedure and dresses the tooth appropriately. A further radiograph is taken confirming the presence of the fractured instrument and Ms J informs Mr Z about this (although this is later disputed). Mr Z is given another prescription for antibiotics and an appointment is made for him to return in a week's time.

DAY 22

Following administration of appropriate local anaesthetic, Ms J makes a second attempt to remove the fractured instrument from the canal but again is unsuccessful.

Mr Z later alleges that Ms J told him that there should be no problem leaving the broken instrument in the tooth as it is sterile. Ms J restores the tooth with an MOD restoration and advises Mr Z that she will refer him to the local dental hospital should further symptoms arise. Ms J does not complete the root canal treatment of the other root canals that do not contain the fractured instrument.

Mr Z returns to the surgery complaining of discomfort in the tooth. Ms J makes a routine, non-urgent referral which is sent by post but is not received at the dental hospital.

DAY 72

Two months on from his last appointment Mr Z phones the dental surgery to inform them that he has not heard anything from the dental hospital. He advises the practice that he is now suffering persistent pain from tooth 46. Ms J makes an urgent re-referral. Mr Z attends the dental hospital and is treated by Dr K who removes the existing restoration, locates the fractured instrument but fails to remove it. A second attempt is made one month later that is also unsuccessful. Following discussions with Mr Z and given the difficulties of treatment so far, Mr Z opts to have the tooth extracted.

Three months' later Ms J receives a letter of claim from solicitors acting on behalf of Mr Z alleging clinical negligence in the treatment of his tooth. A report has been produced by a restorative dentist that is critical of Ms J's treatment of the patient. MDDUS advisers and solicitors review the report together with all associated correspondence including the patient records.

It transpires that Ms J's record-keeping is inadequate and that there is no written treatment plan or reference in the records to the radiographs taken. No note can be

found to refute Mr Z's claim that he was not informed of the instrument failure until a follow-up appointment. An expert instructed by MDDUS to provide an appropriate report is very critical of Ms J in terms of failure to comply with radiographic legislation, failing to comply with antibiotic prescribing guidelines as well as being critical of Ms J's suggestion that the tooth would be asymptomatic because the fractured instrument had been sterile.

Further discussion with Ms J regarding the paucity of the dental records reveals that she did not report her radiographic findings appropriately, did not record the use of dental dam or any instrumentation or irrigation prior to the use of the spiral filler. This casts doubt on the actual treatment that was provided.

Following detailed discussion with Ms J and considering the identified weaknesses, it is agreed that the claim should be settled. It is accepted that the separation of an instrument during endodontic treatment is not negligent. However, the failings by Ms J in terms of discussion with Mr Z and recording of this highlight her vulnerabilities. An amount is negotiated based on the cost of a single implant to replace the missing tooth.



KEY POINTS

- Ensure that accurate, complete and contemporaneous records are kept of all treatment visits together with treatment plans and discussions with patients.
- Memory cannot be relied on in legal defence.
- Please be open and up front with patients when complications occur, being mindful of one's duty of candour.

Aubrey Craig is head of dental division at MDDUS



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ISLANDS IN THEIR DREAM PRACTICE

Hard work and personal sacrifice have paid off for Pearse and Hazel Hannigan who have taken a tired old surgery and created a modern, innovative business that offers their patients a welcoming and peaceful environment

When Pearse and Hazel Hannigan first saw the dental practice housed in an attractive Edwardian house in Muirhead, near Cumbernauld, they knew it was exactly what they wanted: large rooms and communal spaces, a car park at the back and on a busy road – perfect for the new Hannigan Dental Care practice. The only problem was it was practically dilapidated.

Pearse said: “It had everything we wanted, but it was in such a poor condition. The building was 100 years old and had been a GP surgery for much of that time, but for the last 10 years or so had changed to a dental surgery. It had been run with three associate dentists with the owner

based in England and there had been little investment in the practice. However, it had a good patient base and experienced and loyal staff who have stayed with us to help build our practice up.”

After five years practicing dentistry with Greenlaw Dental Care in Paisley, Pearse was ready for a new challenge, and that meant owning and running a practice of his own.

The University of Glasgow graduate explained: “I’ve always had an entrepreneurial streak as my family in Derry ran a property businesses so, even as an undergraduate, I was always thinking about running my own practice. I felt that my time with Richard Alexander at Greenlaw had given me a good grounding in running

a dental business, particularly the amount of admin that goes on in the background to make a business a success, so I was looking for a practice to buy near to where my wife and I lived in the Kirkintilloch area.”

The couple bought the property in August 2016 and, while Hazel continued with her dental sedation work at Hallcraig Dental Care in Airdrie, Pearse ran a single surgery on the ground floor of the newly named Hannigan Dental Care practice.

However, in addition to looking after patients and managing his team he was also co-ordinating a team of construction workers who arrived in September to repair the roof and replace all the windows. Pearse also decided to reconfigure the site of the

entrance, creating the main door to the practice on Station Road rather than its original location around the corner on a side road. This also allowed for a ramp for disabled access.

He said: “It was a bit of a building site for a while but as a lot of the work was on the first floor and above we were able to run the practice on the ground floor without too much disturbance to our patients.”

For phase two of the building programme SAS Shopfitters were commissioned to create a new look for the reception, waiting room and communal areas as well as the two surgeries and other rooms on the ground floor.

Pearse said: “We wanted to recreate the feel of a hotel lobby



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rather than a clinical setting so that patients would feel comfortable and at ease. We re-sited the reception right in front of the entrance so the first thing that our patients would see coming into the practice would be a smiling face. We fitted out the waiting room with comfortable seating and used a simple but attractive colour scheme of off-whites and different tones of grey to create a clean and peaceful ambience.

“We lowered the ceiling in the waiting room and incorporated overhead mood lighting as well as air conditioning for the comfort of our patients. Looking at the end result, I think Dereck Lang and his team at SAS Shopfitters did a remarkable job.”

The off-white and grey colour scheme is repeated throughout the building, particularly on the original wooden panelling, which has been preserved on the walls and up the stairs to the first floor. There is also clear signage throughout the building to help direct patients to the three dentists ‘suites’, which are named after Scottish islands and have their names etched on to their glass doors: Iona, Harris, and Arran.

“We’ve called our waiting room a ‘patient lounge’ and refer to the surgeries as ‘suites’



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We are delighted to have been a part of this project for Pearse, Hazel and the team, and wish them all the very best for the future.

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with evocative Scottish island names to create a welcoming and non-clinical atmosphere at the practice.”

The practice has also upgraded its phone system, allowing reception to answer multiple calls simultaneously, and revamped its entire IT system with support from Systems for Dentists. As a result, the reception has now gone paperless with signatures taken on tablets, and receipts and treatment plans emailed to patients.

Dominic Greer, sales manager at Systems for Dentists, said: “It’s fantastic when a practice embraces new and innovative software products. Pearse and his team have really transitioned to our practice management software with

such ease, and it makes all the hard work we put in worth it, from developing new features right through to our support and admin.”

The final phase of the redevelopment of the practice is just finishing on the first floor where a new state-of-art clinic has been built by IWT Dental & Services. They were also responsible for the refurbishment of other clinics in the practice in addition to providing the flooring, plumbing and electrical works through to the final décor. Modwood, the bespoke dental cabinetmakers, supplied the cabinetry.

The practice has installed a compressor supplied by Dencomp Systems and a Durr Dental suction

motor, with all the LDU equipment provided by Eschmann. The practice has two Belmont Clesta chairs and one from Stern Webber, and NSK provided all the practice hand pieces.

In addition to the three dental clinics, Hannigan Dental Care has also converted three rooms within the building for its partner services, Diane Hunter Physiotherapy and WilsonGrant Podiatry. Diane offers treatment in the practice’s recently renovated Skye suite on the ground floor while podiatrists Stephanie Wilson and Michael Boyle now work out of two converted suites on the first floor.

Newly qualified dentist John McCall joined Pearse in August 2018, and at

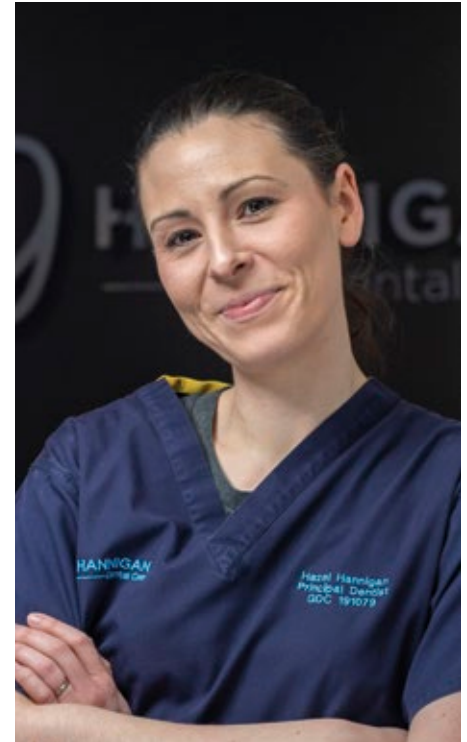


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WONDERFUL AND IT'S
THE FIRST TIME IN MY
PROFESSIONAL LIFE WHERE
I HAVE WORKED IN A
SURGERY WITH A WINDOW”**

the beginning of 2019 Hazel came on board after taking maternity leave following the birth of their daughter Ada in March 2018.

With the building work finally completed and a full complement of staff, including three dentists, seven dental nurses and a hygienist under the watchful eye of experienced practice manager Jacqui Dougan, the Hannigans are now looking to expand the services they can offer at the practice, specifically through sedation referrals and implants. Pearse has just completed an implant surgery course with the Scottish Centre of Excellence for Dentistry and is now looking to offer this service to his patients, while Hazel is keen to use her specialism in sedation techniques to take on referrals for anxious patients.

She said: "Our recent successful NHS sedation inspection has given us approval to offer a range of support for anxious dental patients. There are lots of techniques we can offer from the Alpha-Stim relaxation aid that uses electrotherapy stimulation to help relieve symptoms of anxiety quickly and safely without any medication or injections, to the Wand computer-assisted anaesthesia system, supplied by Dental Sky, which gives pain-free



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→ injections. We can also providing IV sedation that helps patients relax too before dental procedures.”

Hazel said getting married in 2015, opening the surgery in 2016 and then having a baby in 2018 was quite a whirlwind experience, but she loves the renovated practice and particularly her new surgery. She said: “The practice looks wonderful and it’s the first time in my professional life where I have worked in a surgery with a window. It’s so nice having the natural light and knowing what the weather is outside.”

Over this period, the Hannigans had to make a lot of personal sacrifices to realise their dream, which included selling their home and moving in with Hazel’s parents in nearby Bishopbriggs to help finance the project.

Pearse said: “Although it was hard work and difficult at times, to be honest I enjoyed the whole process – it was fun. We have to say a big thanks to Patricia Munro of Strictly Confidential for her expertise in helping us buy the practice and to Royal Bank of Scotland to help finance the project. And, of course, we could not do it without the support of our parents: they’ve been brilliant too.”



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THE GROWTH OF IMPULSE

In the six years since Impulse Dental was established in February 2013 it has enjoyed impressive annual growth.

Indeed, the lab now has almost 10 times as many clients as it did in those early days.

Owner Paul McFall said: "When I started the business we were doing work for 32 dentists, mostly based in and around Glasgow. Now, I provide a service to approximately 300 dentists located as far afield as Fort William, Birmingham and Ireland."

That growth has been based on excellent service and generated by recommendations and word of mouth. When an associate leaves a practice and moves to another they keep using Impulse. Their new colleagues find out about the lab and try its service.

"Among other things, we work under magnification, which was a game changer for me when I was first introduced to it," said Paul.

"It allows you to see small but significant elements of an item that you would not ordinarily see. It allows you to create a better finish and better marginal fit.

"Plus, a high number of dentists work under magnification. And if they are doing so it's important for the lab to do the same. Precision work is only possible when the right procedures are followed at every stage of the process."

A robust quality control system and top-quality training for technicians help minimise chairside adjustments by the dentist.

Paul takes a personal interest in quality of the work being done by Impulse. In fact, he checks and signs off every job that leaves the lab.

That thorough approach pays off. The lab processes approximately 100 cases a day but its remake ratio of between 1 and 2 per cent is remarkably low.

And even though the lab has seen

significant expansion, Paul is determined to retain a very personalised service. He said: "Often, if you phone Impulse Dental Laboratory you'll get me on the phone.

"I value dentists' time and they regularly call to speak about a restoration or aspect of work and I am always available. I've forged some really close relationships with dentists and dental practices – the personal touch helps build and maintain those."

One longstanding relationship is with Hannigan Dental Practice in Glasgow. "I did work for Pearse and Hazel when they were associates in previous practices. When they subsequently opened their own practice we've gone on to develop an even better working relationship that has proved beneficial all round."

The service Impulse delivers depends on excellent resourcing and technology. Paul said: "Among other

things, we now have two state-of-the-art 3shape and Roland CAD/CAM systems that allow us to turn work around much quicker, which is great for our dentist clients and their patients. In fact, we have a fully digital workflow, with the ability to work from intra-oral scans."

Equally crucial to success is the quality of Paul's team. "I now have 13 technicians and four delivery drivers. There's a great balance of experienced hands and enthusiastic young people. Some members of the team previously had their own labs and have the skills and expertise that our clients appreciate."

Such has been the expansion of Impulse Dental that increasing its presence in Shettleston Road through the purchase of another property is a distinct possibility. Should that come to pass it would be further proof that first-class service, talented staff and leading-edge equipment provide solid foundations for growth.

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"We moved to SFD in December 2018 and have absolutely no regrets. The software is easy to use and our team have transitioned very quickly. The customer support is fantastic, if we have any problems, we call the team and they sort it out immediately. SFD seem to be continuously improving the software and have lots of additional features that other systems do not have which make life much easier. The prior approval system in particular has been a great help".



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ISLAND PRACTICE IS PERFECT FOR PATIENTS

Dental patients on Islay and Jura have good reason to celebrate – a brand new, state-of-the-art practice has been opened to serve communities that, until now, have depended on the public dental service.

The dentist who has created the practice from scratch is Marcin Paradowski.

He explained: “We opened on 1 February. I had been working at Islay hospital for about three years before that, but my long-term aim was always to offer patients a full time alternative to the PDS.”

During those three years Marcin had taken time to find an appropriate building, obtain warrants and planning permission and complete the transformation. Until he took over, the premises had been a hardware and paint shop.

The long preparation period had given him the time to think about the practice design.

“I knew that if we wanted to grow and make it future proof we had to have several treatment rooms; we have four in total, two of which are completely equipped right now.” While he uses one, the other is being made ready for an as yet unidentified VT who will start in August.

Crucially, he was keen to have the practice laid out



carefully so that it was simple and easy for all patients to move from reception to waiting room to treatment room. “One major challenge was creating disabled access,” said Marcin. “The floor of the building was higher than the pavement outside, but the pavement was so narrow there was no room for a ramp. We had no option but to lower the height of the floor. This involved a great deal of carefully planned and executed work.

Imagination, as well as hard work, has gone into the practice. For example, the waiting room has a distinctive central lighting panel showing an image of the sky. The four treatment rooms are

complemented with a compressor room and LDU. First-class staff facilities include a staff room and shower.

Marcin was keen to make sure the practice had market-leading equipment. Accordingly, he asked Systems For Dentists to provide all IT hardware and software, chose a suction pump supplied by Durr Dental and, among other things, Promed AG03 chairs and a Villa Endograph X-ray system provided by Profi Dental of Birmingham. The LDU units – Little Sisters SES2020N and SES 3000 B – were supplied by Eschmann Equipment.

“I was very pleased with the service they provided because they made every effort to come out and see me,” said Marcin. “Other wouldn’t give that level of service.”

Currently the only dentist on the island, Marcin has 3,100 registered patients. He undertakes oral surgery and endodontics but occasionally refers patients for sedation and other cases. Meanwhile, there’s a monthly orthodontic clinic at the hospital.

Marcin believes patients are delighted with the practice. “I’ve received a great response. Patients say they love the building and are very grateful to have the service in the community.”

LITTLE-KNOWN TAX TRAPS

How to make the most of allowances available through pensions and investments

“I’M PAYING HOW MUCH IN TAX!?”

This is not an uncommon phrase when clients are made aware of the true amount of tax they are paying.

Most of us receive our income, whether via salary, profit-share from our practice, or a combination of both, without too much thought as to the amount of tax paid. Understandably, our attention goes straight to the net figure, the bottom line that pays the bills and buys the bubbly.

However, it tends to turn a few heads when people discover they have been paying an effective income tax rate of 61 per cent. Yes, that was 61 per cent – it wasn’t a typo.

How could we possibly pay that amount of tax?

Well, the problem exists for those drawing more than £100,000 in income. For every £2 one earns over £100,000, we lose £1 of our personal allowance.

This results in a 41 per cent higher tax rate and the loss of the tax-free allowance, which combines to create an effective 61 per cent for income tax. Ouch. And that’s not accounting for any National Insurance contributions, which would add another 2 per cent.

The 61 per cent tax band exists on a band of earnings between £100,000 and £125,000.

Thankfully, there are some solutions to



Andrew Reynolds,
Chartered Financial
Planner at Anderson
Anderson & Brown
LLP

this problem. Dentists can make use of salary sacrifice to lower their income and boost pension provision.

Pensions, particularly after the changes in 2015, are one of the most flexible vehicles available to dentists, especially when the practice can contribute on their behalf (which as an added bonus will lower the amount of Corporation Tax payable).

Another idea could be to consider tax-efficient investments, such as ISAs or the lesser-known Enterprise Investment Scheme (EIS).

The old saying that the only two certainties in life are death and taxes still holds water, but this should not stop us making the most of the allowances available.

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Michael is a private general dental practitioner with a special interest in dental implantology. As well as looking after his own patient base, he accepts referrals from his network of practices.



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To register for this free event, email: events@condieshealth.co.uk



Date: 21/05/19 | **Time:** 6.30pm – 9.00pm | **Venue:** DoubleTree by Hilton Hotel Edinburgh Airport
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THE BODY CORPORATE

A limited company is commonly viewed as a simple structure, but it involves a number of significant obligations that dentists need to be aware of

Most dentists know that for some years they have been permitted to operate their practice using the structure of a limited company. In the dental world, such a company is known as a Dental Body Corporate (DBC). Many practices were formed as, or converted to, a DBC largely for tax reasons. This article doesn't cover any tax issues which flow from DBCs, but we would recommend that dentists considering forming a DBC take advice from a solicitor and an accountant who specialise in advising dentists and understand the specific issues which potentially affect the tax position of DBCs.

There are various rules around the structure of a DBC, including the requirement that at least 50 per cent of the directors within the company must be registered dentists or registered dental care professionals.

Many dentists who operate as a DBC see it as a very simple structure, and to an extent that is correct. However, it must be borne in mind that limited companies carry with them a number of legislative obligations, such as making certain returns to Companies House.

Unfortunately, we often find that DBCs are operated without a great deal of regard for these obligations. Often the answer we get is that "my accountant formed the company, they will deal with all of that..."

However, the accountant isn't the person who has the obligations, it is the dentist as a director of the company.

The areas to watch out for within the context of a DBC include:

- How do the dentists share income?
 - Unlike a dental partnership where you have complete freedom to decide how to share the profits of the partnership, within a company there is slightly less flexibility – you need to decide what the respective returns from the DBC will be. Whatever it is, you should discuss that with your solicitor and your accountant to ensure that your desired outcome can be achieved.
- How will profits be extracted from the DBC? – Whatever the required profit sharing is, you also need to decide how to extract it. In a partnership, the partners simply share profit in an agreed manner. A popular misconception is that it is no different in a company. Shareholders in a company often take the simplistic approach that "it's my money anyway". Sadly that isn't the case. The revenues generated by the practice belong to the company, and the shareholders then need to decide how to extract their portion of that. That might be partly by dividend, partly by salary, etc., and exactly how the money comes out should be decided upon in conjunction with your accountant's advice.



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

- What happens when a dentist wants to leave or otherwise reaches retirement? – Once again, in a partnership the dentist simply states his intention to leave or retire – the partnership agreement will govern what happens from there in terms of realising the value of the departing/retiring dentist's interest in the practice. With a DBC, your value is in most cases tied in with your shareholding. You therefore need to be able to sell the shareholding, either to the remaining shareholders or to an incoming dentist. However, the company's Constitution (Articles of Association and/or Shareholders Agreement) will govern how freely (if at all) those shares can be sold, and there may therefore be obstacles to overcome when you come to leave. This subject should be fully discussed by the principals at an early stage so that the position for the future is clear.
- A very simple thing – One requirement of all companies is to maintain various Statutory Registers, showing its shareholders, directors, etc. Easy to do, but we regularly get a blank look when we ask about the registers. A poorly maintained (or worse still non-existent) set of registers can cause huge issues, particularly on the sale of a DBC. So ensure that these are kept up to date from the outset.





* Pictured: Thorntons Dental Team

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SCOTTISH MARKET FUELLED BY INCREASING BUYER APPETITE

Paul Graham, the newly appointed Head of Dental at Christie & Co, discusses demand and trends among various buyer profiles within the Scottish dental market

The Scottish market remains positive for owners looking to sell their dental practices. The Central Belt of Scotland and neighbouring regions remain the key focus for buyers, attracting more attention as market activity remains robust.

We are seeing high demand from private multiple practice owners, and it is this particular buyer profile which dominates the market. However, we have also seen an upturn from first-time entrants, which plays a crucial role in fuelling activity at the lower end of the market.

Increasing enquiries from private equity and other investors, attracted by the solidarity of the sector, is another interesting trend of the current market. Looking for larger, associate-led practices, they have a similar appetite to the acquisitive private multiple practice owners. The scalability of a practice comes high on their list of priorities, with four or more surgeries and the principal staying on post sale being of particular interest.

We have recently completed on a number of these types of sales where not only was the price achieved well in excess of market value but terms in favour of the seller were also



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delivered. Too often we see sellers who have been dealing directly with a buyer, receiving unfavourable and unrealistic conditions attached to a mediocre offer.

In recognition of the different needs and demands of various buyer profiles, Christie & Co offers a bespoke service tailored specifically for the seller. Unlike many agents who agree to take fees from both buyer and seller, we view this as a conflict of interest. By taking a confidential, "whole market approach" to selling a practice, we have the expertise to deliver the vendor's objectives in a fair marketplace.

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NEW TAX YEAR – 2019/20

With the income tax regime for those living and working in Scotland becomes more complex, now is the time to scrutinise your accounting and taxation affairs

As we embark on a new tax year, now seems like a good time to evaluate your accounting and taxation affairs.

It is extremely important, as dental professionals, to consider the options available to ensure any decision making is based on current accounting and taxation legislation. Ask yourself – do you operate in a way that fits your business and personal goals for today and beyond?

Working and living in Scotland unfortunately means you are going to pay higher income tax than your English counterparts.

You'll recall the UK Chancellor raised the limits for the basic rate band for 2019/20 to £50,000 but Derek Mackay, the Scottish Finance Secretary, decided to leave the

Scottish basic rate band at £43,430.

His justification for this was to raise additional tax revenues, though our experience is that this encourages tax avoidance and may actually raise less revenue. The Scottish bandings and rates for 2019/20 are in the table below. Note that these bandings apply to taxpayers entitled to the full

personal allowance of £12,500.

Confused? All these rates making your head hurt? It seems Mr Mackay is tinkering with the tax rates and simply making matters unnecessarily complex.

It will be interesting to see, in the long term, if dental entrepreneurs are willing to accept the higher tax position in Scotland.

Over £12,500 to £14,549	Starter rate	19%
Over £14,549 to £24,944	Scottish Basic rate	20%
Over £24,944 to £43,430	Intermediate rate	21%
Over £43,430 to £150,000	Higher rate	41%
Over £150,000	Top rate	46%



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

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WHAT DEPOSIT IS NEEDED TO BUY A PRACTICE?

Jon Drysdale considers the frequently asked question about the size of deposit required from a purchaser

A sufficient deposit is critical to buying a practice. Unlike with residential property purchases there is no minimum size of deposit and no published scale of interest rates linked to deposit levels.

CAN YOU BORROW 100 PER CENT OF THE PURCHASE PRICE?

While there is no minimum deposit, banks don't routinely lend 100 per cent on the purchase of dental practice goodwill – that is a myth! Perhaps if you have an existing practice or practices, already with minimal borrowing, or significant alternative security to offer, the deposit might be negated.

JUST THE DEPOSIT MAY NOT BE ENOUGH

If your purchase includes a property, banks will usually lend 100 per cent of its freehold value – you generally only need a deposit for the loan for the goodwill value. The goodwill value may not be the price you pay. In recent years NHS practices have sold for more than the asking price.

Alternatively, you may agree a purchase price which is the asking price or less. Most banks (not all) will insist you instruct one of their panel of valuers to give an independent valuation. The valuation may be lower than your offer. You could try renegotiating the amount you offered – this is unlikely to go down well with the vendor.

In each of the above cases the bank will usually expect you to make up the difference – *in addition* to any deposit requirement.

WHEN THE DEPOSIT IS IRRELEVANT

The profit from your new business needs to meet your finance costs *and* your usual personal expenditure. Banks assess finance costs by reference to the loan repayment amount and by 'stress testing' against the possibility of rising interest rates. Below is an example – for a loan against goodwill and a loan against property.

1. A £450,000 loan for the dental practice goodwill with repayment over 15 years means annual repayments of £39,136 (Bank of England base rate 0.75 per cent plus 2.95 per cent).

2. Increasing the interest rate by 2.75 per cent (to 6.45 per cent) brings the annual repayments to £46,891.

3. Further stressing the borrowing by multiplying the repayments by 1.25 results in annual repayments of £58,614.

A. A £150,000 loan for a freehold property repayable over 25 years means annual repayments of £9,060 (Bank of England base rate 0.75 per cent plus 2.80 per cent).

B. Increasing the interest rate by 2.75 per cent (to 6.30 per cent) brings the annual repayments to £11,930.

C. Multiplying the repayments by 1.25 (as above) results in annual repayments of £14,912.

Under maximum stress, the combined annual loan repayments would be £58,614 + £14,912 = £73,527.

The net profit for this practice is £160,000. Deducting approximately £50,000 for tax, the available drawings will be £110,000. Under maximum stress, the prospective owner is left with just £36,473.

- Few dentists could convince a bank this is enough to live on.
- To verify personal expenditure the bank will request 12 months of personal bank statements.
- If the prospective owner argues their spouse or partner earns enough to cover living costs, payslips/bank statements would need to prove this.
- The practice probably isn't profitable enough for the bank to lend to the prospective owner or they are seeking to borrow too much.

AND NOW THE DEPOSIT

I didn't refer to the deposit in the above example as it is largely irrelevant – banks lend on the 'serviceability' of loans rather than the size of deposit. To proceed with the



Jon Drysdale is an independent financial adviser for chartered financial planners, PFM Dental. Go to www.pfmdental.co.uk

purchase in the example, the prospective owner has two options.

1. Try to renegotiate the price to be paid. This is unlikely to go down well with the vendor or their sales agent. It is the purchaser's responsibility to secure the finance.

2. Borrow less or increase the deposit. Either option will make the figures look more favourable. For example, increasing the deposit by £50,000 reduces the stress-tested finance costs.

If as a prospective purchaser you don't run the finance cost analysis before making an offer, you may not be able to secure finance. Agreeing to buy a practice and subsequently not coming up with the finance means a sales agent will be cautious about future offers you make.

OTHER FACTORS THAT COUNT

A bank doesn't assess a deal on the finance costs alone. If your case is marginal and you simply don't have additional cash funds to offer, you will need to support your case in other ways:

- Can you offer the bank security such as equity in a property?
- Can you raise separate finance for your deposit?
- Could you buy with a colleague or friend?

HOW DO WE HELP?

As finance brokers and sales agents, at PFM Dental we see the problems of raising finance from both sides and have worked with many dentists to overcome them. Our chartered (dental) accountancy team is skilled at providing projections for your proposed practice purchase and our legal team will help if you are purchasing a practice from another sales agent.

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Assurgo Associates offers bespoke business development expertise and a range of services to dental practices who want to focus first and foremost on their patient and clinical services but realise that they would benefit from professional business advice and hands-on support while only wanting to commit to flexible or interim resources.

A FLEXIBLE SOLUTION

Assurgo provides advice, strategic reviews and valuations to businesses looking to buy and sell practices; assists business owners to open new practices or expand and refurbish existing practices; writes business plans for funding bids; develops and implements marketing strategies and provides financial guidance and project management on a flexible basis.

Founded by healthcare specialist Michelle Le Prevost, Assurgo has a team of highly experienced associates who come from a variety of specialist backgrounds such as project management, marketing and communications, finance and



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procurement who have a shared interest in providing interim support and adding long-term value to dental practices in Scotland.

ADVICE FROM OUR ASSOCIATES

Whether you are at the point of expanding, retiring, or even not sure what direction your practice is moving in, discussing your plans, recognising the challenges and taking advice can help focus your business strategy.

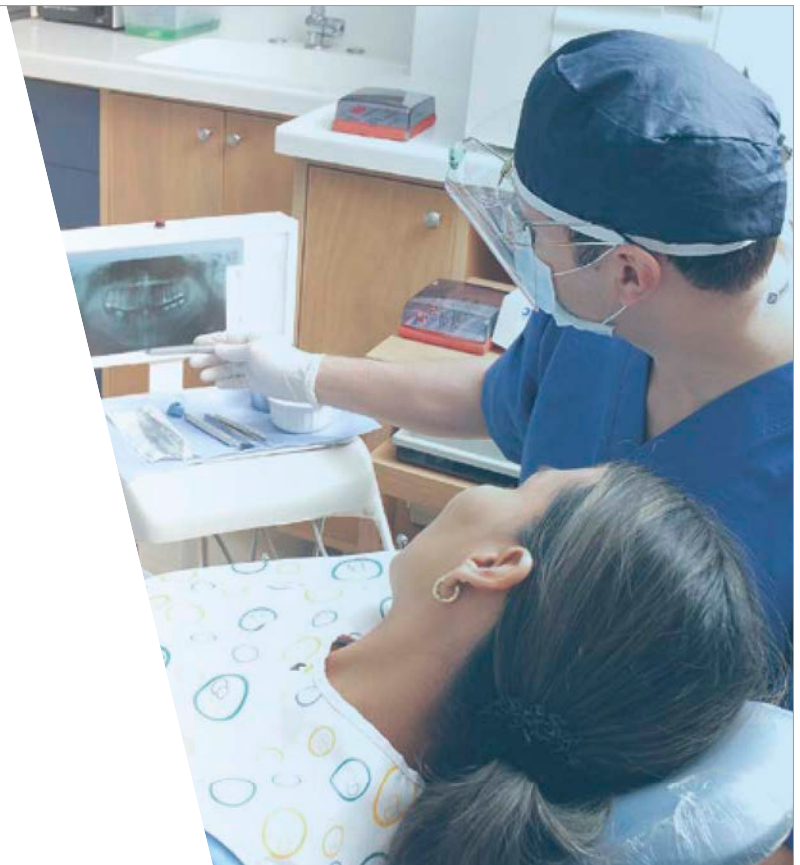
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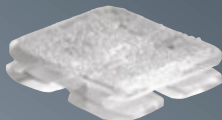
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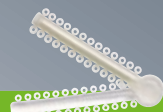
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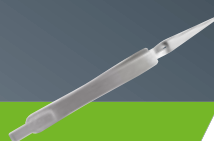
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We see both children and adults, both NHS and private patients and we are happy to provide specialist advice for any cases that our dental colleagues may require.

The Orthodontic Clinic is proud to have gone from strength to strength since 2014 when it was bought over by the current directors. Our reputation and professionalism is something we pride ourselves on and we're humbled that our hard work has been acknowledged in the awards we have won. It's our aim everyday to show our patients and our dental colleagues that we want to give the best care that we possibly can. **The Orthodontic Clinic** - trust us to take care of your patients to create those perfect smiles.



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LESS REASON FOR DOUBT

Significant breakthrough in prevention-focused dentistry as innovative technology allows early detection and management of dental caries

Working within the dental profession can be significantly rewarding but requires commitment and dedication. The provision of quality dental care demands the delivery of clinical excellence, safety and a good patient experience and, like most healthcare systems, continuous improvement is fundamental for the advancement of services.

Most patients understand the concept of preventive dentistry. When they visit the practice they expect their oral health to be evaluated and the mouth to be examined for any signs of oral disease and decay. Central to prevention-focused dentistry is the ability to detect disease at an early stage, and in the case of dental caries; assess the degree of demineralisation and instigate the correct intervention to inhibit further decay.

Clinically, practitioners rely mostly on visual signs such as colour and changes in the tooth enamel to detect dental caries. When documenting the teeth, practitioners typically describe the teeth as sound, early or caries. However, it could be argued that many diagnoses described as “early” lesions or “early and progressing into the dentine” may be subjective and perhaps one should question the term “early” because it has the potential for several different meanings or stages. However, the International Caries Detection and Assessment System (ICDAS) provides a standard method for caries classification, staging and activity evaluation, which has shown to be valid and accurate.¹

This system comprises of seven detection codes in total, two of which enable clinicians to define the term ‘early’ more precisely:

1. Sound tooth surface
2. First visual change in enamel
3. Distinct visual change in enamel
4. Localised enamel breakdown
5. Underlying dark shadow from dentine

6. Distinct cavity with visible dentine
7. Extensive cavity with visible dentine.

There is no doubt that dental practitioners want to detect dental decay at the earliest possible stages (i.e. when the enamel first begins to lose minerals) so that measures can be taken to reverse it and prevent further destruction. Radiographs can be very effective for identifying interproximal enamel lesions; yet, detecting early enamel lesions on the occlusal surfaces can be more challenging. For instance, by the time caries is visible on a radiograph it is usually quite extensive and it can often be difficult to determine whether or not a lesion is active. Without knowledge that a lesion is active, or enough evidence to confirm that the tooth is sound, the only option is to put a “watch” on the relevant tooth for specific monitoring to see if it remains the same or becomes worse.

With definitive evidence of active demineralisation, preventive therapy such as the application of fluoride, along with behavioural changes by the patient, can be implemented to prevent the tooth progressing to the cavitation stages. However, until now there was no precise way to evaluate the remineralisation and improvement of the tooth. As a result, practitioners may *think* that the tooth looks better, but they are obliged to continue keeping a “watch” on it.

Fortunately, a significant breakthrough has recently been made in the management of dental caries with the world’s first biotech dental device.

The CALCIVIS system uses a specific photoprotein that produces bioluminescence in the presence of free calcium ions as they are released from actively demineralising tooth surfaces. This innovative technology displays a glowing map of ‘hot spots’, or active lesions, as a visual map at the chair side, which enables practitioners and their



Flo Couper, Dental Hygienist, Educator and Product Specialist at CALCIVIS®, where she supports dental professionals with the integration of brand new biotechnology to visualise and advance the management of early caries

patients to see the very early signs of caries long before surgical intervention is required.

As the CALCIVIS imaging system captures and visualises calcium ions so precisely, it offers additional reassurance and confidence to dental practitioners faced with the challenges associated with the detection and management of early caries.

The CALCIVIS imaging system also provides a means of assessing the efficacy of reparative or remineralisation therapies. For example, a tooth that may have previously been put on “watch” can be regularly checked for activity more effectively.

The CALCIVIS imaging system also improves the patient experience by providing an effective communication tool that helps patients to better understand their oral health status. The engaging images clearly demonstrate the importance of good oral hygiene and help to motivate patients into making improvements and behavioural changes to prevent further dental decay and disease.

By examining and assessing the latest advancements in dental technology and research, practitioners are better able to make improvements in early caries detection and management. Certainly, with the ability to see things more clearly, there should be less reason for doubt and, practitioners are better equipped to deliver excellent levels of prevention, treatments and high-quality care.

For more information visit www.calcivis.com, call on 0131 658 5152 or email at info@calcivis.com

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WHY IS PRIMARY STABILITY SO IMPORTANT?

The factors that influence the level of primary stability are bone density and quality, implant shape, design, surface qualities and surgical technique. Consequently, NobelActive was designed to feature an expanding tapered implant body that gradually condenses bone, and an apex with drilling blades that helps guide surgical precision².

As such, NobelActive has been found to offer high initial torque in all qualities of bone. Furthermore, its high primary stability is considered particularly advantageous for placing the implant alongside sinus lift procedures.³ Owing to its unique engineering, the NobelActive system is well suited to thin ridges, minimizing – if not eliminating – the amount of bone grafting required⁴ and making procedures more efficient with shorter healing times.

NobelActive is also suitable for potentially challenging indications and protocols, including immediate placement and immediate function. This is because these implants help achieve good primary implant stability.⁵

Dr Amit Mistry, of Amit Mistry Implants, says: "I started using Nobel Biocare implants because of their compatibility with concepts like immediate function and immediate loading appealed to me. I also like that the products have a lot of research behind them... they can be trusted to provide predictable and consistent results."

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The implant helps ensure high-quality aesthetics. Following surgery with NobelActive implants, gingival thickness was sufficiently maintained to provide a naturalistic appearance.⁶ Furthermore, built-in platform shifting helps optimise hard and soft tissue volume, and patients report high satisfaction with results.⁷

Dr Abid Faqir, implant surgeon, says:

"I have used the NobelActive implant since its launch in 2008; in fact, I was part of the pre-launch group. I use it mostly for maxillary implant cases. It is very effective in soft bone and has really good stability and a great connection."

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NobelActive is highly suitable where space is restricted, such as with the lower incisors. Its stability, even in limited bone, makes it useful in clinical situations where other implants would be unfeasible.¹¹

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ICON OPTIM Interdental brushes by Stoddard are the Strong, Flexible and Durable Interdental brush range, available in a range of nine colour-coded sizes that will be familiar to all.

The brushes are precision-made by Stoddard Manufacturing Company Limited, a family-run business, established in 1934 and located in Hertfordshire. ICON OPTIM Interdental brushes are manufactured using only the highest specification materials. High tensile strength, plastic-coated, stainless steel wire at the core prevents the brushes from buckling. The brush is locked into the handle using a revolutionary production process making it virtually impossible for them to separate.

The range, which starts with a smaller-than-some-other-brands white brush, measures 0.35mm in diameter and then follows the sizes and colours that patients are

familiar with, ending with a grey 1.30mm brush. ICON OPTIM gives the quality and long-lasting brush you need, at a cost that will keep you and your patients smiling.

Findings of a recent trial* (A survey of BSDHT hygienists 2018) showed 84 per cent of the hygienists who took part reported that ICON OPTIM Interdental brushes performed better overall than the brand they were currently using; 84 per cent also stated that the strength of the wire core was superior to their current brand and 88 per cent reported that they were more cost effective, for both practices and patients, than their current brand.

ICON OPTIM brushes are available in packs containing eight or 25 brushes, of a single size/colour, with caps that double as handle extensions, if needed. They are available from most dental wholesalers.

Also available for dental practices are

patient information leaflets, reception display stands and a smaller "mini" stand that shows the colour and sizes of the full range.

For a free sample come and find us at The Scottish Dental Show, stand number B07.



Looking for a stronger Interdental brush range at a price your practice will love?

**ICON[®]
OPTIM**

84%
of dental hygienists
said ICON performed
better than their
current brand*
*In a recent study of BSDHT hygienists



by **Stoddard**

British quality design and manufacture since 1934



RETIREMENT IS WASTED ON THOSE TOO OLD TO ENJOY IT

Dentist David Row reflects on his career and why selling his practice has let him make the most of life

I won't be alone when I say that dentistry is a fast-paced profession, especially when juggling it with a busy life outside of work, time can pass by quicker than you realise.

For me, that realisation is especially pertinent because, as I write this, I'm days away from retiring from the career I've spent the last 40 years building.

At 57 it's come a few years earlier than I'd planned, but a mixture of health and circumstance mean that the time's right for me. What's more I'm thoroughly grateful that my line of work – along with the decisions I've taken within it – has given me the opportunity.

DECIDING ON DENTISTRY

When people ask what inspired me to become a dentist, I tell them it was the dentist I used to visit as a child: he was so bad, that I knew I had to do better!

On a more serious note though, like many of my peers there are three main things that really drew me to the profession.

The first was the appeal of the practical work – I've always been very hands on, so it suited me well. Second was the fact that I got to work with people. I've built up some great relationships through work,

both on a personal and a professional level. Third, dentistry is one of the few professions where – with enough hard work – you can really be your own boss.

BRANCHING OUT

I took my first associate job in 1986 and landed my first partner role in Ashington in 1990. Back then I honestly thought I could work forever. The buzz of being a partner really spurred me on, and when I was given the opportunity to join my current practice, Kelvin Lodge in Newcastle, I jumped at the chance.

Three of us bought in at a similar time and the practice, already well established, went from strength to strength. We all had our own areas of interest – both in terms of dentistry and the practical side of running a business – and I was able to focus on implants and surgery. We maintained

a good reputation both locally and beyond, and to this day we still have patients coming back from as far as Italy, France, Greece and even Russia.

SELLING UP

As we reached our mid-50s though, we all realised that there was more we wanted to do inside and outside of work. This combined with the growing administrative efforts needed to keep the practice running and compliant, meant we started looking for one of the associates to buy in.

The plan fell through but, at the same time, we were contacted by one of the large dental groups asking if we'd consider selling. After exploring it further, we decided this provider wasn't for us as we felt they'd undervalued the practice and were suggesting terms that we didn't want to accept.

Shortly after we were contacted by Bupa Dental Care. Immediately we knew that their offer was different and we were impressed by how much they understood the practice.

They recognised that we were a strong performing practice and so were happy to let us keep running without interference. We sold the practice to them in January 2016.



Dental
Care

A FRESH APPROACH

While we've been able to maintain an independent approach to practising, Bupa has provided a huge amount of admin and clinical governance support. Ultimately this has meant we're able to focus on patient care and team development, without being distracted by the paperwork and challenges that comes with IT, HR, overheads and equipment.

It's honestly like being back to when I first started out: I'm back to working 9 to 5 and can leave without the stress hanging over me.

All was going swimmingly until, 18 months ago, I suffered a serious heart attack.

During this time I had the stark realisation that, if I hadn't have sold the practice, there's no way that I would have taken the time needed for a full recovery. Our practice was built on us sharing the workload and – while my colleagues are nothing but supportive – I'd have personally felt I was letting them down by not returning to work.

Instead, Bupa were hugely supportive and were able to give me the time off that I needed – both at the time of the heart attack and surgery itself, and when I had to take time off for back problems. They were able to bring in additional dentists too, who proved such a good fit that they're now staying on at the practice.

LOOKING TO THE FUTURE

After 40 years, I've understandably got mixed emotions about leaving the profession. For all the stress of the CQC inspections and the late nights earlier in my career, I've also been lucky to work with some brilliant people, and will certainly miss the camaraderie with my colleagues. Likewise I'll miss my patients too, though I know that I'll be bumping into them on the golf course instead, which doesn't seem like such a bad compromise!

On the plus side, I know I'm leaving the practice in good hands. What's more, I'm looking forward to getting some more travelling under my belt, in particular surprising my 85-year-old mother with a trip back to her native Kenya. It'll be a poignant trip but one that makes me feel grateful for the fact that I've got plenty more trips ahead, while young enough to enjoy them.

Bupa Dental Care

If you're considering selling your practice, or just want to hear more about your options for the future:

Call: 01454 771 575

Email: m&a@bupadentalcare.co.uk

Visit: bupa.co.uk/

sellingyourdentalpractice

Bupa Dental Services are provided by Bupa Dental Services Limited. Registered office: 1 Angel Court, London, EC2R 7HJ. Registered number 479557.





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



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For more information call the team on 0131 564 1822 or visit newlifeteethlab.co.uk.

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FOR WHITENING THAT **STANDS OUT** VISIT US AT **STAND F01**
AT THE SCOTTISH DENTAL SHOW, 26-27 APRIL 2019

BOUTIQUE
WHITENING



Rachel Moreland

Tel: 07854 725 544

Email: rachelm@dmg-dental.co.uk

Web: uk.dmg-dental.com

The DMG brand is recognised in more than 80 countries and is marked by several innovative milestones, including Luxatemp, now celebrating more than 20 years of international success – quite a remarkable achievement for a temporary crown and bridge material. ConStic self-etching and adhesive flowable composite is a new three-in-one flowable composite which combines etching gel, bonding agent and flowable composite in one single product; and Icon, DMG's revolutionary treatment for incipient caries and carious white spot lesions, represents a breakthrough in micro-invasive technology.



Allan Wright

Tel: 07803627247

Email: allan.wright@a-dec.co.uk

Web: gb.a-dec.com

A-dec have recently welcomed Allan Wright as their new Territory Manager for Scotland and Ireland. Allan is based in Glasgow and is a dental industry veteran, having previously worked at Schülke and Henry Schein. He has done a great job so far of getting stuck in; meeting with our dealers and customers across Scotland and Ireland to build an even stronger A-dec support network for them. Allan is passionate about helping the dental team to provide exceptional treatment for patients through innovative and ergonomic products.

If you'd like to say hello, you can reach Allan on 07803627247 or at allan.wright@a-dec.co.uk



IWT Dental + Services

Tel: 07477 939 104

Web: www.iwtdental.co.uk

IWT Dental + Services provides a full range of dental services direct to the dental practice, to include dental chair packages, dental furniture, installation, maintenance and service provision, surgery design and construction, IT server-based networks, AV solutions and phone systems. IWT also offers comprehensive service agreements for all products to ensure a service level second to none. Directors Ian Wilson and Bruce Deane have a wealth of knowledge in the dental sector having worked in the industry for more than a decade. Ian is currently director of IW Technology Services.

IW Tech provides specialist IT solutions to dental practices throughout Scotland, including server-based network installations, waiting area digital signage/patient information, business telephone systems and Cloud Backup solutions.

All offered products are complemented by a proactive maintenance service agreement, which includes regular site visits to ensure all IT systems are functioning correctly.



CALCIVIS

Flo Couper

Tel: 07970541222

Email: fcouper@calcivis.com

Web: www.calcivis.com

Flo has worked in the dental profession for 29 years and is passionate about preventive dentistry. She has coached many dental teams and continues to support clinicians as they integrate biotechnology to advance the management of early caries. The CALCIVIS system uses bioluminescence to visualise active demineralisation at its earliest, most reversible stages. This innovation represents a significant step forward in minimally invasive dentistry.

Flo works with clinicians and dental teams in Scotland and the North of England that are committed to offering patients the best possible dental experience to help them to achieve optimum oral health. Speak to her about enhancing the way you practice, empowering your patients, growing your revenue and setting your dental practice apart from the others. For more information visit www.calcivis.com, call on 0131 658 5152 or email at info@calcivis.com



Dental Sky

Tel: 0800 294 4700

Email: sales@dentalsky.com

Web: www.dentalsky.com

With a mission to keep dentist working seamlessly, Dental Sky is one of the fastest growing dental supply companies in the UK. It supplies the dental profession with practically every dental product you need to run a successful practice.

Dental Sky has many exciting exclusive products such as the award-winning computer-assisted anaesthesia system, the Wand STA, and the innovative oral cancer prevention screening glasses, Goccles!

Dental Sky offers great prices and deals on the everyday products you need to keep your practice running smoothly. It also offers a great rewards point scheme that gives you one point for every £1 you spend online. Once you have collected 300 points or more, they can be spent on a range of products from the loyalty gift catalogue, with gifts such as chocolate, gift cards, iPads, Xboxes and more. With great customer service, next day delivery and an easy to use website, Dental Sky helps to keep your practice working seamlessly.



COLTENE

Helen Wilson

Tel: 07788 146109

Email: Helen.wilson@coltene.com

Helen has many years of experience working in the dental profession. Having begun her career as a dental nurse, she joined a dental product supplier 13 years ago and has been with Coltene UK for nearly eight years now.

As the Territory Manager for Scotland, Helen's primary role is to deliver exceptional customer service to every practice that uses the innovative products from Coltene UK. She visits practices whenever she can to provide all the information and support dentists need. She also organises lunch and learn sessions in order to build effective working relationships and demonstrate solutions first hand.

Having worked in a practice herself, Helen understands how important after sales support is for the dental team. She is always at the end of the phone should professionals have questions and she will go out of her way to resolve any issues as quickly and efficiently as possible.



BSC DENTAL Nursing



Our BSc in Dental Nursing, which is validated by the University of the West of Scotland, allows you to study while you work as a dental nurse!

Not only will it enhance your skills and knowledge in the profession, it will place you at the top end of your career, providing you opportunities for your future.

The course is offered full-time or part-time in state-of-the-art dental training facilities in our Coatbridge Campus.

Entry requirements

To apply, you must be registered with the General Dental Council and be in employment or have a placement (minimum 16 hours per week) in a dental practice.

You must also hold a 240 credit HND in Dental Nursing or 120 HNC in Dental Nursing and an additional 120 credits gained via dental related qualifications. You will also have the support of a GDC registered dentist who will act as a mentor.

GOT ALL OF THE ABOVE AND INTERESTED IN APPLYING?
Follow this link: www.nclanarkshire.ac.uk/courses/dental

> TRYCARE



NEVER TAKE A SHADE AGAIN!

Up until now, in order to provide the optimum in aesthetic composite restorations it was necessary to spend a considerable amount of time taking an accurate shade match. And, to be honest, even then it was sometimes wrong when the patient got out of the chair.

Tokuyama, one of the world's biggest and most innovative dental manufacturers, has eliminated the cost and inconvenience of both of these problems with the introduction of Omnichroma the world's first shadeless composite.

Tokuyama's shadeless Omnichroma combines patented "structural colour" pearl technology with their advanced resin expertise so that just one shadeless Omnichroma and Omnichroma Blocker is all you need to replace all 16 Vita shades of any other composite system.

This means that with Omnichroma there is no need to shade match ever again because just one pack saves the time and cost of on average 20 shade matches per syringe or pack of PLTs.

For more information about the e Tokuyama range, contact your local Trycare Representative, call 01274 885544 or visit www.trycare.co.uk/omnichroma

> DURR DENTAL

ALL-IN-ONE DIAGNOSTICS

Dürr Dental have developed an extended version of their VistaVox S panoramic machine which contains six additional programmes for time-saving cephalometric exposure with minimum radiation doses, called VistaVox S Ceph.

As you'd expect from Dürr, exceptional diagnostics and ease of use are guaranteed. Alongside the 17 panoramic programmes, the VistaVox S Ceph has several orthodontic applications, including 'Lateral Head', 'Full Lateral Head', 'PA Head' and 'Waters View'. The unit is as fast as it is smart – with a scan time of just 1.9 seconds, images are exceptionally sharp using the lowest possible radiation dose. This functionality is afforded by the high-sensitivity CSL sensors. The unit can switch effortlessly between the 3D X-Ray and the Ceph boom. It has a perfect 3D imaging volume of 130mm (compared to 80x80mm for most other systems). This means it completely covers the whole diagnostically relevant area. Enhanced visibility does not require a higher radiation dose; in fact, the opposite is true. A special curved path, which rotates 540°, in combination with a tightly collimated fan beam and a highly sensitive Csl sensor, means a particularly low radiation dose is used.



www.duerrdental.com

> CALCIVIS®



SEEING BEHIND THE SMILE

Adult orthodontics, high-end restorations such as veneers and natural coloured inlays/onlays and crowns are in high demand. But to help your patients to successfully maintain their investments, use the CALCIVIS® imaging system.

The CALCIVIS imaging system uses a specific photoprotein that produces bioluminescence in the presence of free calcium ions as they are released from actively demineralising tooth surfaces. This is presented at the chairside as a live, glowing map and provides a means of visualising and tracking any changes to tooth surfaces including those at the margins of restorations at their earliest, most reversible stages.

For an early detection system that helps patients to better understand their oral health, contact CALCIVIS now.

To find out more about CALCIVIS visit www.calcivis.com or call 0131 658 5152

> W&H

PRECISION EVERY TIME

When it comes to implant treatment, no two cases are the same.

Therefore, you need tools that will help you to make precise assessments and encourage successful outcomes.

Step forward the W&H Implantmed Surgical Unit with Osstell ISQ module. It can quickly and simply assess the stability of an implant by taking measurements to determine the level of osseointegration. The professional workflow is streamlined and the process is non-invasive. Further still, it aids communication as patients can see the readings themselves.

W&H is a leading manufacturer of high-quality equipment that can help you raise the level of treatment you provide – find out more today.



To find out more visit www.wh.com/en_uk, call 01727 874990 or email office.uk@wh.com

> BELMONT



HOSPITAL UNDERGOES REFURB

Guy's and St. Thomas' NHS Hospital Foundation Trust has recently upgraded and opened a fully refurbished, undergraduate outpatient dental clinic.

The open-plan suite of 28 top-quality dental chairs plus surgery accessories, all supplied by Belmont and fitted by Nesor, provides patients with a high-quality, modern clinical experience and gives students across the undergraduate dental curriculum unprecedented opportunity to use cutting-edge technology and facilities to develop their clinical and operative skills.

The refurbishment was completed in 2018 with minimal disruption to patient care and undergraduate education. The fitting team from Nesor Ltd, overcame the considerable logistical challenges of re-fitting a large outpatient clinic.

Stephen Price, Belmont's director, said: "We're delighted that Guys chose our flagship Cleo model. As well as being cosmetically impressive, it offers significant functionality and practical benefits. Its folding leg-rest makes it as easy to sit in as an armchair, so it's perfect for patient consultations."

For more information on this release please contact: Michelle Hurd, AB Communications, Tel: (020) 8399 6730, E-mail: michelle@ab-communications.com

> SHOFU

DURABLE AND COLOUR-STABLE HYBRID CERAMICS

Whether aesthetic anterior restorations or inlays, onlays and posterior crowns with high colour and surface stability: Shofu Block HC can be used for almost all indications for modern CAD/CAM technology and machined wet or dry in all standard milling units. Shofu has added two-layer blanks to its line of hybrid ceramics and fitted blocks with universal holding pins. So Shofu Block HC, a high-performance CAD/CAM material, is now available in three types (Universal, Cerec and Ceramill) and as one and two-layer blocks. Users may choose from various high and low-translucency shades and two enamel shades, designed to meet every need in the field of all-ceramic restorations.

The excellent physical properties of Shofu Block HC allow the creation of crowns and implant-supported restorations characterised by great durability and absorption of occlusal forces. Moreover, highly aesthetic restorations can be created thanks to enamel-like light transmission and the addition of two-layer blocks featuring a smooth, natural shade transition from dentin to enamel.



For further information please contact Shofu UK on 01732 783580 or sales@shofu.co.uk

> CARESTREAM



CONVENIENT AND WELL PRICED

Carestream Dental speaks to Dr Anoop Maini, dentist at Aqua Dental Clinic in London, about his experience using the CS 8100 3D imaging system.

"My patients love the CS 8100 3D as it saves them the inconvenience of having to go to another clinic for a scan, plus they think the technology is really fantastic.

"I would 100 per cent recommend the system as not only is it well-priced, but it offers multiple fields of view, high resolution and a small footprint – a real 10/10."

Find out more today.

For more information, contact Carestream Dental on 0800 169 9692 or visit www.carestreamdental.co.uk For the latest news and updates, follow us on Twitter @Carestream-Dentl and Facebook

> NOBEL BIOCARE

BUILD A STRONG FOUNDATION

Primary stability plays a key role when it comes to predicting implant success.

So why not build a good foundation with NobelActive™ implants from Nobel Biocare?

Promoting high stability and excellent esthetics, these unique implants have been especially designed for use in demanding clinical situations such as soft bone or extraction sockets.

The implant's expanding tapered body condenses the bone gradually during insertion, helping to anchor the implant into the available bone with ease. Furthermore, due to their unique shape and cutting blades, these implants can be angled during placement, allowing clinicians to achieve optimized restorative orientation.

Find out more today.



For more information, contact Nobel Biocare on 0208 756 3300, or visit www.nobelbiocare.com/nobelactive

> COLTENE



COLTENE LAUNCHES BRILLIANT COMPOSITE FOR CHAIRSIDE

COLTENE will launch BRILLIANT COMPONEER™ at the British Dental Conference and Dentistry Show.

BRILLIANT COMPONEER™ is a composite material that offers high-gloss retention, excellent polishability and outstanding stability. It can be used for minimally invasive, quality restorations that can be carried out chairside – no laboratory necessary – in one session.

Its range of indications include restoring carious defects, fractures and old restorations, reconstructing lost tooth substance, extending incisal edges, cosmetic corrections and more.

BRILLIANT COMPONEER™ is the latest addition to COLTENE's high-performance, cost-effective range of solutions for restorative, endodontic and general dentistry.

This May, make sure to visit COLTENE at stand K52.

To find out more visit www.coltene.com, email info.uk@coltene.com or call 01444 235486

> DURR DENTAL

SMART TECHNOLOGY FOR THE SURGERY

Chances are many of us are using smart technology within the home, to control our heating, lighting or alarm systems. Now the same pioneering technology is available to make your working life as simple. Dürr Dental have launched their new IoT (internet of things) solution called VistaSoft Monitor, to ensure that the practice runs smoothly and intuitively.

This cloud-based IoT service solution allows all connectable Dürr Dental systems to be integrated into VistaSoft Monitor, providing a clear overview of all products, including compressors, autoclaves and x-ray systems. The software is based on the principle of 'monitor-transmit-analyse-act'.

The units constantly monitor important operating parameters and transmit them in real time to VistaSoft Monitor, where they are analysed and then presented to the user in a clear format. Operation can be viewed centrally at a PC in the reception area, or decentralised in every treatment room or on a smartphone/tablet via the corresponding app.

Potential problems are detected in advance, i.e. if the fill level of the amalgam collecting container is reaching its maximum an alert will be sent to ensure a replacement is ordered in plenty of time.



www.duerrdental.com

> DURR DENTAL



CLEAN WATER WITHOUT CHEMICALS

Dental treatment systems offer ideal conditions under which biofilm can form and micro-organisms such as pseudomonas, legionella and cryptosporidium can flourish. These micro-organisms can be exposed to the patient via the cooling water, mouth rinsing water and aerosol exposure. Hygowater from Dürr Dental ensures the service water in your practice always meets the same stringent requirements as drinking water. This standard is consistent with the advice given by the Robert Koch Institute.

Water-carrying systems in treatment units can still, however, harbour various micro-organisms, which can colonise and form a biofilm which adheres to the inner walls of the unit. To ensure optimum safety micro-organisms must be reduced to a minimum and biofilm permanently removed from hoses and pipes.

Hygowater is a system that promises safe and reliable service water processing. It fulfils all legal requirements for water hygiene as well as satisfying the meticulous standards demanded by the German Drinking Water Ordinance as well as meeting the requirements for a Class I medical device.

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> BELMONT

LATEST TOUCH-SCREEN X-RAYS

Belmont Touch is the new touchscreen x-ray from Belmont. Despite its technology being advanced, the product couldn't be simpler to use. The easy-clean screen produces instant error code reports and has multi-lingual functionality. It also switches into 'sleep mode' to conserve energy and contains a USB port and handheld exposure switch which can be wall mounted. Belmont Touch is also aesthetically appealing and has a zero-drift scissor-arm, which means it can be neatly stowed away against the wall when not in use.

Belmont Touch is compatible with any type of digital imaging system. Not only does it reduce the soft x-rays absorbed by the tissues, making it safer and more reassuring for patients, but the tube voltage, current and exposure time can all be selected according to the individual clinical need, helping to avoid unnecessary exposure to radiation.

Offering a minimum exposure time of just 0.01 seconds, the Belmont Touch pre-programmed timer is selectable for digital systems and two different types of films. A total of 16 film speeds are available and the lightweight, compact, easy to hold tube head enables the operator to align the tube accurately every time for re-producible, high contrast, crisp radiographs with excellent image quality.



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TAKE-HOME AND IN-OFFICE TEETH WHITENING



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VISIT US AT
STAND A15 AT
THE SCOTTISH
DENTAL SHOW
2019

Meet the Team



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